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# DETROIT MEDICAL JOURNAL

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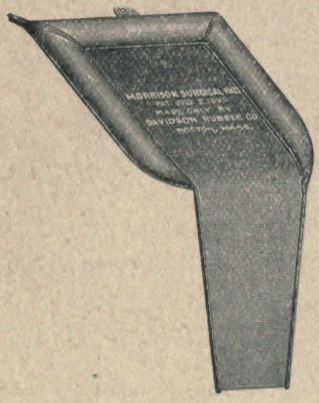

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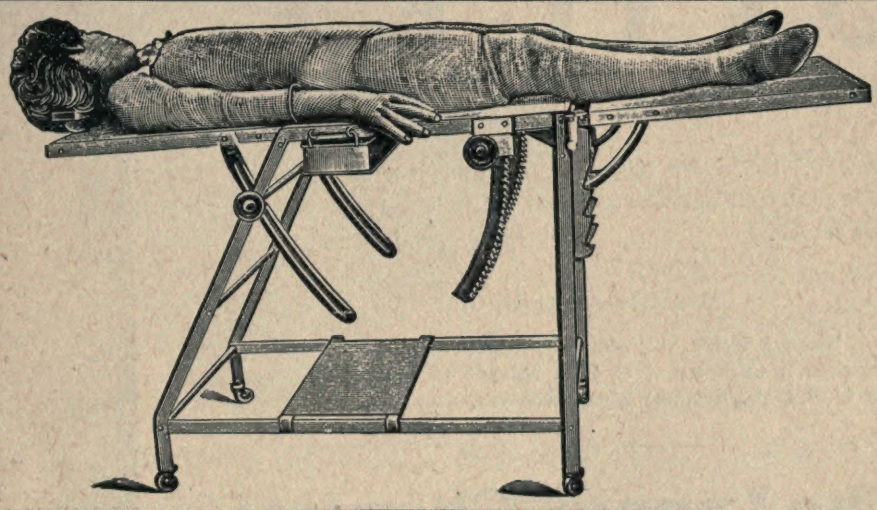

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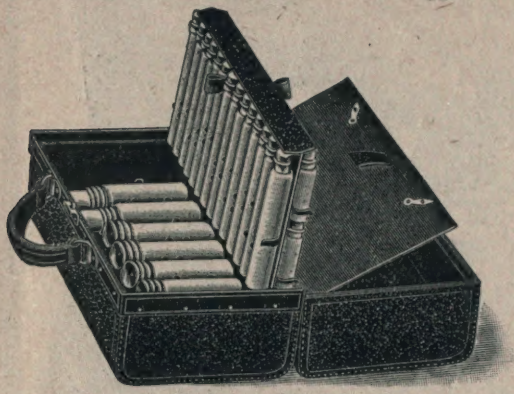

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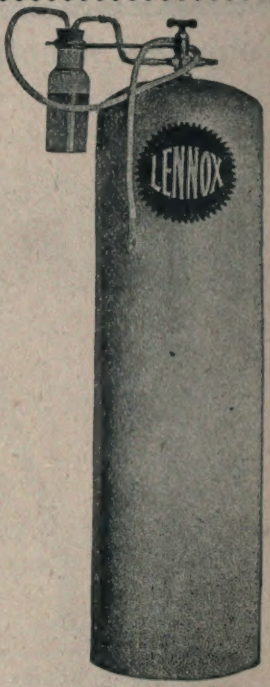


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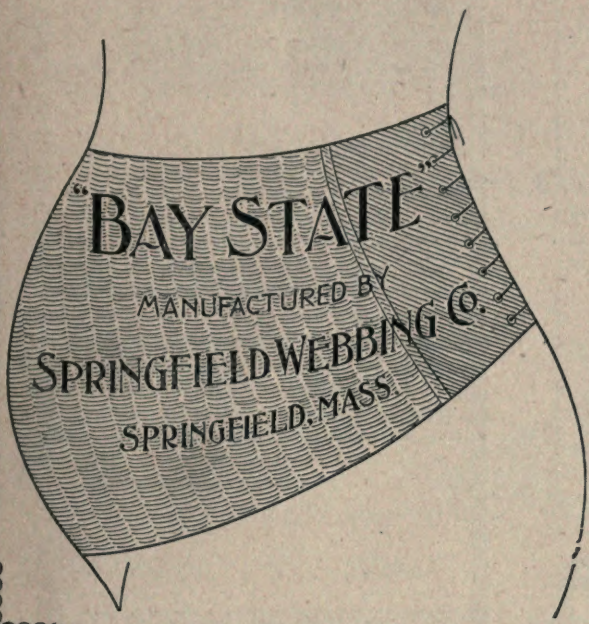


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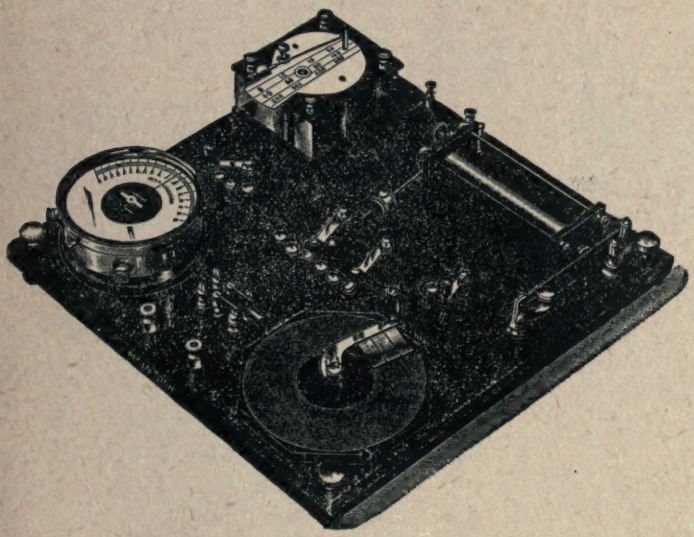

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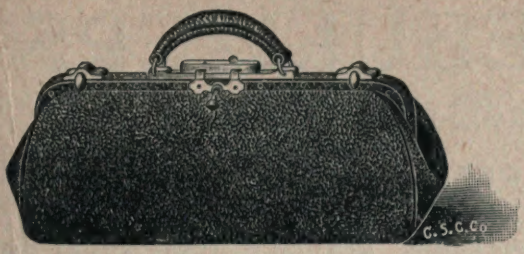


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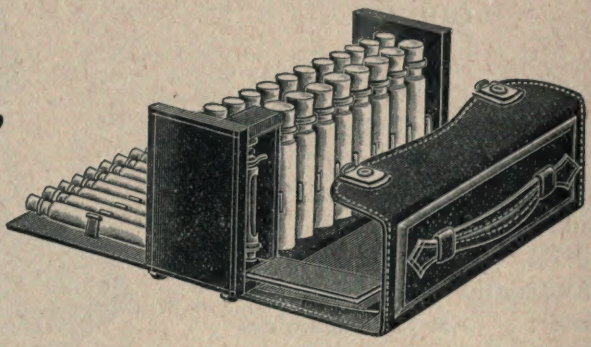

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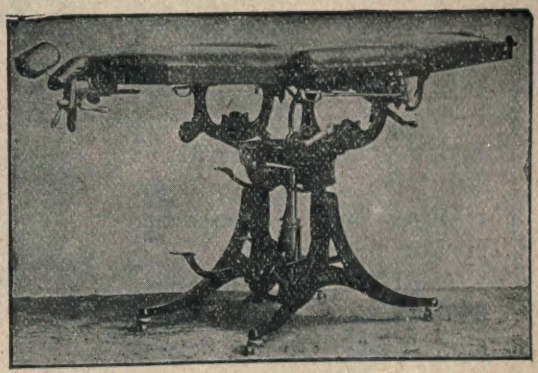

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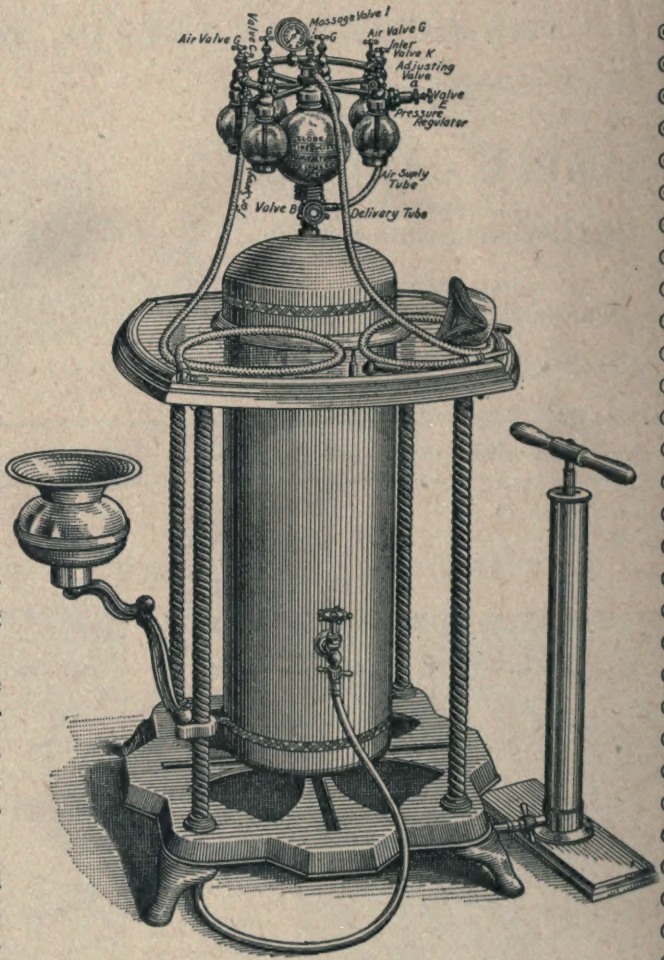


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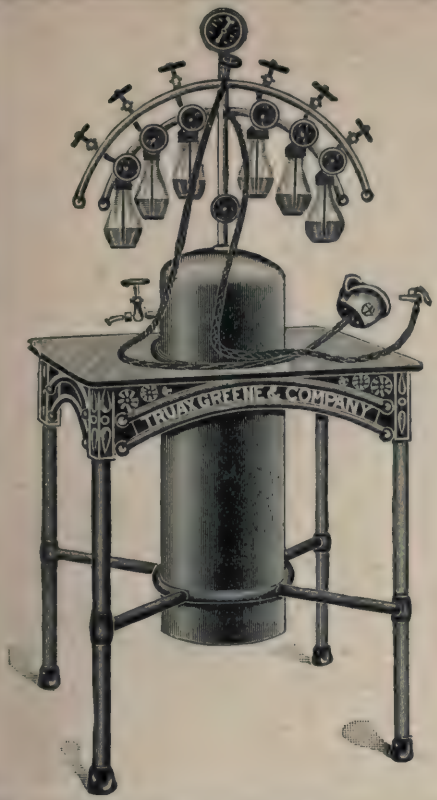


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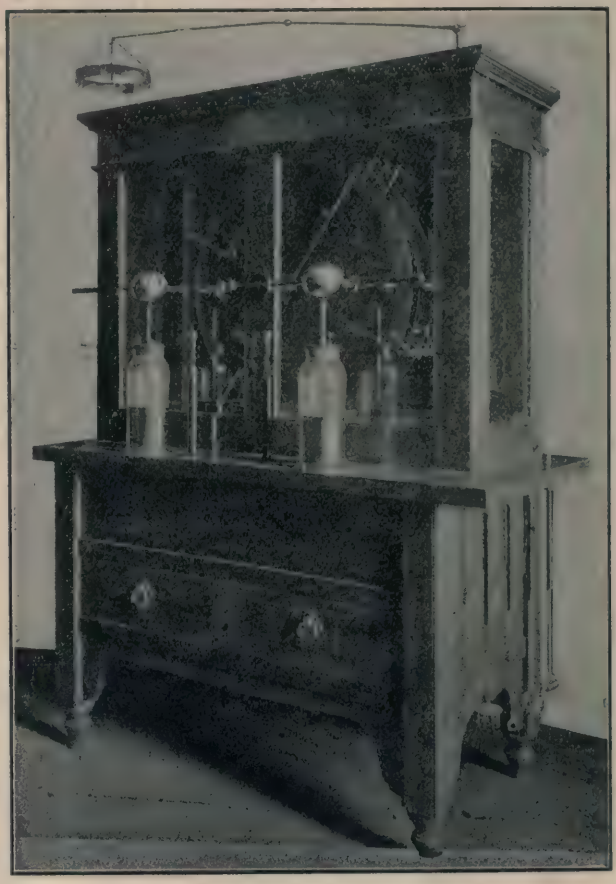

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Fig. 1.

Fig. 2.

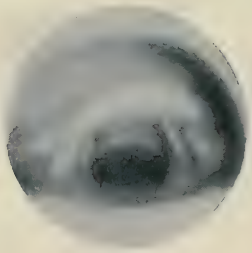

Fig. 3.

Fig. 4.

Fig. 5.

SEE DR. SPRANGER'S ARTICLE ON "THE SINGING VOICE."

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# ORIGINAL ARTICLES

## PATHOLOGICAL CONDITIONS IMPAIRING THE SINGING VOICE.*

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The changes in the singing voice produced by pathological conditions may be divided into four classes: Changes of

1st. Clearness.
2nd. Power.
3rd. Range.
4th. Flexibility.

In changes of clearness the symptoms may be objective or subjective. The singer may not realize any impairment himself, especially in the early stages; or the patient may imagine or experience changes in clearness when they do not exist, or are not heard by others.

Loss of clearness of tone is usually caused by foreign sounds, mixed with the voice—viz: Nasal, laryngeal, buccal or tracheal sounds, such as rattling or a faint piping sound.

All foreign sounds in the singing voice can best be diagnosed while the patient is singing "mezzo voce," without accompaniment. One can hear defects which indicate serious pathological changes in the "piano voice" long before they exhibit themselves in the loud or "forte" tones. The patient will invariably insist on singing with full voice or with accompaniment, but the "mezzo voce," must be adhered to in order that the sounds may come to our ears clearly.

The tone itself may be changed, becoming musically poor, or the attack on a definite note may be too high or too low in pitch, the voice after the primary attack, remaining at the proper pitch. The tone is invariably attacked a shade too high and it then instantly drops to the proper pitch when the "coup de glot" is continually used. The other extreme, of too low an attack and sliding up to the proper pitch is most largely found among singers who exaggerate the "legato" effect or who use an "H" sound before each vowel.

The several variations from pitch may persist during the whole sustained tone, this being attributed to lack of pitch or a "false ear," but in reality it is more often produced by pathological changes in the vocal bands. The instances to verify such a condition are too numerous to ignore.

There are cases in which artists have absolute pitch in playing the violin but, when they are singing, are only semi-occasionally on the proper pitch. In one instance that has come to my own knowl-

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edge, an artist accompanied his voice with masterly touch and absolute pitch on the violin, singing at the same time at least a quarter-tone flat, especially in the upper range. Many singers while they are themselves singing unconsciously "off the pitch" can instantly detect a defect of the same kind in other voices.

These conditions are usually caused by the vocal bands not vibrating in unison, one imparting an impulse to the current of air slightly slower than that given by the other. This condition is due to a unilateral weakness of the vocal bands or a weakness in the nerve supply to one of them. This allows one band to vibrate in response to the correct impulse conveyed by the sense of true pitch, and the other to lag behind.

These conditions are easily detected and the defective vocal band determined with the aid of the Stroboscope, by tuning the revolving disc of the instrument to the exact pitch of the tone that the patient is attempting to produce, when in the Laryngeal mirror the defective vocal band will be seen to vibrate slowly or irregularly; or one can observe the vocal bands swinging at variance with each other by slightly reducing the speed of the revolving disc.

Another form of variation of pitch is exhibited in the tremolo voice, where the attack is either too high or too low and continues to alternate throughout the entire sustained tone. This may become such a habit that in fully developed cases the vocal bands will show their conflict very plainly, with the aid of the Stroboscope.

Pathological changes affecting the power of the singing voice can be divided into two classes:

1st. Changes of Endurance or Durability.

2nd. Changes of Intensity or Strength.

Changes of endurance or durability are recognized in the early stages of any affection by the following symptoms: (a) The tone begins well but grows weaker. This is usually due to Anæmia, Scrofula or specific conditions and diseases of the lungs and thorax: (b) Changes of timbre or quality, loss of brightness or freshness; the voice sounds dull or nasal. Timbre or quality defects are usually due to mechanical changes, such as Chronic Rhinitis, Hypertrophy of the Turbinates, Enlarged Tonsils, Laryngitis, acute or chronic thickening of the mucous membranes either general or circumscribed, the symmetry of the larynx, changed, crossing of the arytenoid cartilages, tumors, tuberculous or benign, and singers' "Noddles."

The timbre or quality defects not due to mechanical changes are produced by abuse of the singing voice, such as harmful methods of singing, too frequent use of "forced" tones, and *loss of gentle placement of attack,* or carelessness in properly placing or concentrating *each tone before applying force or power to it;* and by producing unmusical sounds, such as loud laughter, repeated sneezing, shouting, or continued coughing.

The quality or timbre of a voice rapidly deteriorates when a singer employs a faulty method of articulation. Many are the instances in which a voice may show the greatest promise in timbre, range and flexibility while exercises or scales are being sung with a pure vowel sound, only to be completely ruined when advance to an attempt to sing words is made, solely because of a faulty articulation. Changes in quality or timbre may also be produced by decreased resonance due to acute or chronic affections of the nasal accessory sinuses.

We cannot emphasize too strongly the importance of the part contributed by the nasal accessory sinuses to the resonance of the singing or speaking voice, especially the antrum of Highmore.

After long and interesting experiments we have determined that the quality or carrying power of the voice depends al-

most entirely on the formation and physical condition of these resonating cavities. We can safely compare their importance to the voice, with that of the body of a violin or the sounding-board of any instrument. Each superior maxillary sinus has an internal capacity of from 30 to 45 ccm., the inferior surfaces and the lateral nasal surfaces remaining free to vibrate when the current of air from the larynx is properly focused against the anterior portion of the roof of the mouth, called the "forward placement of the voice" by vocal teachers.

The floor of the superior maxillary sinuses and of the nasal cavities has a measurement of more than 2 by 3 inches, to which may be added an equal area of lateral nasal surface and in the case of most well trained vocal artists, the anterior walls of the fossæ Caninæ can be included: for it will be observed that they unconsciously make use of a tension of the upper lips and tissues covering the anterior wall by assuming a forced smile. By this means the flabby tissues attached to the anterior wall are changed to a tense membrane, free to vibrate with the resonating cavity.

The importance of the assistance these large vibrating areas give to the voice has been long overlooked, and in our opinion the superior maxillary sinuses serve only for this purpose.

In experiment we have changed the character and power of the singing voice by partially filling the antrum of Highmore with saline solution through the ostium maxillaris and by thus decreasing the air capacity and retarding the vibrations of the antrum floor and the nasal walls with the weight of the solution, we have produced a change in the voice not at all unlike that produced by the application of a "mute" to a violin bridge.

Variations in the thickness of the mucous membranes in the nasal accessory sinuses play an important part in changes of the quality of tone. By acute inflammation or hyperæmia of the membrane, the voice can be impaired and *sometimes even improved.* Instances are numerous in which singers, suffering from a severe cold, will hesitate to sing, but when fairly started they feel they never sang so well in their whole career and they probably will never again be as pleased with their voice unless similar conditions arise; the thickening of the mucous membrane may have caused the proper nasal and sinus capacities to intensify the vibrations of the voice to their utmost.

Realizing the great importance of the resonating or "sounding-board" relation the superior maxillary sinuses bear to the voice and following the well known laws of physics in their application to vibrating diaphragms, we know that the air pressure in these sinuses must be constant with the external atmospheric pressure; and if these bodies of air in the superior maxillary sinuses are confined by occlusion of the natural opening into the nasal cavities, the ostium maxillaris, we then know that the walls of our sinuses will not respond with the proper vibrations, to the current of vibrating air striking them.

We can demonstrate this fact with a "snare drum," at the side of which is a small opening, to equalize the internal with the external atmospheric pressure. If we close this small opening, the hardest blow struck with the drumstick will only produce a dull, muffled sound. We have determined by numerous experiments that the same conditions arise in regard to the power and resonance of the human voice, when the small opening that connects the superior maxillary sinus with the nasal cavities is closed or opened. By passing a small silver tube through this opening when it is found occluded or by making a new opening when the ostium maxillaris is obliterated and leaving a small piece of tubing there temporarily, we have produced most satisfactory results of improvement of the

singing voice, in regard to quality, timbre and even range. This simple operation has proved of the utmost importance in restoring these resonating surfaces to their normal functions.

The laryngeal pathological conditions that impair the singing voice may be placed under three classifications.

First:—Mechanical changes due to abnormal development, crossing of the arytenoid cartilages, acute or chronic, circumscribed or diffuse inflammatory processes.

Second:—Paralysis of one or more of the motor muscles, either acute or chronic.

Third:—Pathological growths. This last classification brings to our notice the most frequent affection of the professional singer's voice, the so-called "singer's noddles." Many are caused by overworking the voice or by improper methods of singing. Even when the cause is removed the trouble may return repeatedly and a permanent cure can be effected only by careful attention to the soft or aspirate attack of the tones, avoiding as much as possible the "coup de glot."

One of the several photographs of the vocal bands (Fig. 1), shows a fully developed Fibroma attached to the edge of the vocal band. This was removed with a Rosenberg's double curette, restoring the voice to its normal function.*

Two others, (Figs. 2 and 4) show tuberculous infiltrations, which were removed with a Moritz Schmidt curette. Both are making a satisfactory recovery.

Fig. 3 is presented as an interesting picture only. The explosion of the flash light startled the patient and the exposure was made during the act of inspiration. It shows very distinctly the bifurcation of the bronchial tubes.

Fiv. 5 shows the normal vocal bands in the act of singing high "G" with the "chest" voice. The details are very clear, most noticeable being the tracing of the blood vessels. The white light reflecting at the juncture of the false and the true vocal bands was produced by particles of mucous.

The laryngeal camera with which these photographs were taken, as well as the operative technique, were acquired through the kindness of the inventor, Dr. Sanitätsrath Musehold, of Berlin. The instrument itself is the handiwork of Herr Oemke, of the Berlin Physiological Institute.

Recognizing the many pathological changes of the respiratory organs that may impair the voice, it has now become the custom in Europe for singers or persons dependent upon their voices, to have a thorough examination of their vocal organs made at regular intervals; and in the larger musical conservatories a thorough examination by a laryngologist and a certificate from him, stating that the vocal organs are in a normal condition, is required from every candidate for vocal instruction—a practice which might well be carried out in this country for the mutual protection of the vocal teacher and the pupil. Cases are not at all rare in which promising vocalists find that after pursuing their studies for some time their voices become impaired; on examination of the vocal organs by a laryngologist, pathological changes are found and the impression is conveyed to the pupil, sometimes unintentionally, that his voice has been abused by a faulty method of singing—whereas, the pathological conditions may have existed and should have been corrected long before vocal instruction was attempted. Such instances can only prove harmful to the career of both the teacher and pupil.

If we are to obtain and maintain the

*Dr. Spranger has made several attempts to secure a photograph of the restored vocal band, but up to the time of going to press he was unable to secure it, owing to the absence of the patient from the city. We hope, however, to be able to show one to our readers next month.—Ed.

efficacy of this wonderful and delicate instrument, which gives to all persons the grandest of musical tones, it is essential that we guard against and correct at the earliest possible moment any pathological changes that may impair the human voice.

270 Woodward Avenue.

## THE VALUE OF ABDOMINAL PALPATION IN THE DIAGNOSIS OF DISEASES OF THE STOMACH AND INTESTINES.*

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When your president invited me to read a paper before the Detroit Medical Society I was anxious to select a subject which would be of interest to the general practitioner. The subject which I have selected is one which, I feel, has not had the attention from the profession that it deserves, and one which is often overlooked in the diagnosis of diseases of the stomach and intestines. I shall speak of Palpation as a method in the diagnosis of gastric and intestinal diseases. Palpation furnishes the most important data for the diagnosis of certain cases of stomach and intestinal disorders. The correctness of its results depends, of course, on the degree of technical expertness in manipulation, for while there are some general rules in the procedure, it may be said that in this as in every thing else much depends on practice and experience.

The abdomen of the patient should be brought before examination into a state of as complete relaxation as possible. The patient should lie on his back, the head should be pressed firmly backward into a pillow, and deep, slow inspirations should be made through the open mouth. The examination, dependent upon the part of the abdomen under observation, is much assisted by flexing the thighs and extending the legs. In some cases it is advisable to elevate the back, though in others the examination must be made while the patient is in the lateral position. The physician should never palpate while standing; in fact, he should avoid every possible disturbing influence, such as the weight of his body; preferably he should sit on the edge of the bed. He should lay his hands flat on the abdominal walls, and should avoid all severe pressure of his fingers. It is best to begin softly, and allow the pressure to become gradually greater, though usually an intense pressure will not be necessary. The hands should always be warm when palpating, for cold hands cause contraction of the abdominal muscles and prevent deep manipulation. If the first examination does not give sufficient results the intestines should be evacuated by a thorough purgation before another examination is made. The bi-manual examination is often quite valuable. The fingers may be introduced into the vagina or rectum, while the abdomen is manipulated with the other hand. In cases where the tension of the abdominal walls is so great that palpation is not practicable, chloroform narcosis may be resorted to.

Palpation determines whether the abdomen is sensitive to pain or not. Sensitiveness to pressure in circumscribed spots might fix the seat of bowel-obstruction. We may find the abdomen sensitive to pressure along its entire extent, and this may be indicative of diffused peritonitis. General meteorism, developed acutely, produces in itself a high degree of hyperæsthesia. Often we can feel through the abdominal wall intestinal loops which are movable. While probing for their contour and thickness we may obtain important hints. We must aim especially at fixing the seat of an obstruction, and we may obtain it by palpating, if we have previously reduced the meteorism. Sometimes the palpating hand discovers an abnormal resistance, which

*Read before the Detroit Medical Society, February 12, 1902.

may prove to be a tumor adjoining the stomach or intestines; or again, we may feel a hard lump and this prove to be a segment of the intestine which through hypertrophy has become thick and stiff and is filled with stagnated material.

The size, form and position of the stomach can be determined by palpation and its boundaries can often be made out with considerable accuracy. The boundarries of an empty stomach cannot be determined; it is only after the stomach has been inflated with gas or filled with fluid that they can be ascertained. Before proceeding to palpation it is advisable to observe whether the stomach is sensitive when expanded; whether the pain is confined to a circumscribed spot or is general; whether it is spontaneous, or occasioned only by persistent pressure. It is important to ascertain whether acute pain or simply an unpleasant sensation results from the pressure. The expression of the patient's face will here be found far more trustworthy than his word. Localization of pain in comparatively remote parts is an important aid to diagnosis. Painfulness in the epigastrium is not always attributable to the stomach and may be due to an inflammation of the left hepatic lobule; nor does hyperæsthesia in the region of the large curvature always point to gastric complication (1). It is impossible to make an exact localization of pain in cases where the pylorus is involved, or the small curvature and its vicinity, unless the stomach be fallen. Sensibility to pressure, merely an uncomfortable sensation without actual pain, is often a premonitory symptom in several kinds of inflammation of the mucous membrane of the stomach. We find this in chronic gastritis, in neurosis of the stomach, in hypertrophy of the pylorus, and in carcinoma not yet sufficiently developed to be amenable to palpation. Circumscribed pain of gastric ulcer is so typical and unique as to be easily distinguished from all other kinds of abdominal pain. This pain is a burning, sore sensation, so that often, while undergoing palpation, the patient will try to ward off the hands of the physician.

For the discovery of tumors, palpation is one of the best methods known (2). The hand must be strenuously pressed against the patient's back, so as to bring the palpating hand into closer contact with the neoplasm. The bi-manual method is preferable in all cases of tumor. The tumor is located by means of the one hand, the pressure applied being gradually increased while the other hand determines size, form, consistency, irritability, flexibility, etc. It is extremely difficult to determine by palpation alone, whether a tumor is attached to the stomach or to some other organ. For example: there is a strong possibility of mistaking a tumor for the pancreas. In a normal condition the pancreas cannot be felt through the abdominal wall, but when the integument is relaxed and the patient emaciated and the stomach empty, the pancreas may be felt in the epigastric region and may easily be mistaken for a tumor. Furthermore, the lymphatic gland situated below the large curvature in the gastro-colic ligament may become swollen under certain conditions, in which case it is not infrequently mistaken for a small movable tumor (3). The stomach is connected with the diaphragm and normally moves during respiration. This point is important in deciding whether a tumor is attached to the stomach or not. Should we find by palpation that the tumor moves downward during inspiration we may conclude that it is attached directly to the stomach walls (4). Tumors of the pylorus are less affected by movements of the diaphragm. A respiratory displacement of a tumor in the pyloric region indicates that the tumor is connected with the liver. The peristaltic movement of the stomach will at times produce sudden disappearance and reappearance of tumors which were easily

palpable but a moment before. The total failure of stomach tumors to respond to this passive displacement points to perigastritis (5). In case the stomach be greatly dilated or sunken, as often occurs in pyloric carcinoma, it follows logically that the tumor is drawn down with the stomach, and when through perigastric adhesion the tumor becomes fixed in this abnormal position, it is apt to occasion error in the diagnosis. It is impossible to palpate tumors in the posterior wall of the stomach unless the stomach be empty; while tumors differently located are best examined when the stomach is filled.

The Algesimeter (6) is an instrument constructed by Boas, for ascertaining the intensity of pain in circumscribed localities. The apparatus consists of a hollow cylinder in which there is a spiral spring. The cylinder is provided with a scale which registers the pressure on the spiral spring, which is from a half to ten Kilo. An indicator follows the spiral in such a manner as to register the degree of the pressure that has been exerted. In order to define the limits of a sensitive locality three plug-like attachments can be connected with the lower end of the apparatus. The test of irritability in the epigastrium indicates the following facts: A normal stomach will endure a pressure of five to ten Kilo. The stomach is most sensitive in the case of ulcer, registering then a slight pressure of one-half up to three Kilo. This test of endurance is so reliable, that, according to Boas, the toleration of a greater pressure practically eliminates the existence of an ulcer. A patient suffering from carcinoma will endure from two to four Kilo. Chronic gastritis and nervous dyspepsia exhibit the least deviation from normal sensibility.

By applying the finger-tips to the stomach with a short, pushing movement, a sort of splashing sound is heard. Under normal conditions this sound can be heard only after the ingestion of a great deal of liquid and as a rule it is not emitted from any part below a line drawn horizontally through the navel. This splashing can at no time be heard in a normal empty stomach. While in dilatation, atony and gastroptosis it is easily produced.

The several sections of the intestines call for a method of palpation peculiar to each part.

It is very difficult to find the duodenum by palpation. Only when we can discover the head of the pancreas, which it surrounds in the form of a horse-shoe, have we an approximate guide for manipulation; it is especially helpful if we can determine at the same time, the position of the gall-bladder (7). If a tumor is present in the ascending section of the duodenum, it lies to the right of the median line within the lower border of the ribs, the navel and the gall-bladder. A tumor thus situated will be found, on palpation, to be easily movable. If the growth arises in the descending or transverse section of the duodenum, it will lie in the same position, but it will be little, if at all, movable, being firmly fixed by the pancreas and the peritoneum.

In contradistinction to the large intestine, palpation of the small intestine does not give good results. Whenever we can palpate the large intestine, we can also determine the extent of the small intestine. When, however, the large intestine can not be palpated, and nothing definite can be ascertained as to its position, then we cannot make out that part of the small intestine which lies between the umbilicus and the pubes. In cases of typhoid fever, after laxatives, enteritis and chronic constipation, palpation is attended with moderate gurgling, which under normal conditions is not observed. This gurgling, however, ceases quite suddenly, unlike that which is observed in the palpation of the large intestine, for after two or three pressures it disappears. The loops of the small intestine which lie in

the right iliac fossa produce a similar gurgling in typhoid fever and cholera asiatica, but of longer duration. The ileum can be palpated in typhoid fever, and it is found quite painful and at times thickened.

The appendix vermiformis can not always be palpated precisely, because of its lack of firmness and the extreme variableness of its position. For palpating the appendix, we must draw the examining fingers in a straight line from the umbilicus to the anterior superior spine of the right ileum. In doing this the pressure exerted should be deep enough to feel distinctly, along the whole route traversed by the examining fingers, the resistant surfaces of the posterior abdominal wall and of the pelvic brim. In this way only can we recognize the normal or the slightly enlarged appendix. In palpating here, it is necessary to press so that we reach the posterior wall and the soft, yielding structure will glide away from the approaching finger (8). The appendix is recognized as a flattened, ribbon-shaped structure, or as a more or less cylindrical, firm organ when its walls have been thickened by inflammation. When it is the seat of inflammatory changes, the appendix vermiformis is more or less sensitive to pressure, while the normal appendix exhibits no special sensitiveness to pressure. It is said that 200,000 cases of appendicitis are annually treated by the physicians of the United States (9). It appears from the statements made by patients to the surgeon that few of these appendices are accurately palpated. An abcess that has formed in appendicitis, and has persisted there for some time, can be palpated and recognized as such.

The cæcum can be palpated only when the abdomen is relaxed. The manipulator sits at the right of the patient in the usual manner, with his fingers slightly bent on the abdominal wall over the right inguinal region, moving them downward and outward in a perpendicular direction above the middle of Poupart's ligament. We try to find the iliac fossa, against which the cæcum can be pressed when palpated. At times the cæcum is higher than the crest of the ilium, and in this case, place the flat part of the left hand under the right lumbar region, making a counter pressure with the right hand. The line which corresponds with the axis of the cæcum goes from within downward and outward and transects usually the linea spino-umbilicalis almost at right angles (10). The cæcum can be felt as a somewhat firm cylinder which becomes rounder and broader the further down we palpate. The pressure produces gurgling. The cæcum behaves in this manner not infrequently in healthy persons. In patients with chronic constipation the cæcum is often found as a resisting body, firm, pear-shaped, movable, and responding to pressure with loud gurgling sounds. This resistant mass is formed by the stagnation of fæcal matter. In hypertrophy of the intestinal walls the cæcum feels like a solid cylinder in varying proportions, contains some gases, but gurgling cannot be produced. The cæcum is distended after purgatives and in diarrhœa of various origins, especially in summer enteritis and gastro-enteritis; but in these cases its walls and its lower border are not clearly palpable but we get by palpation loud gurgling sounds as far as the cæcum extends. This gurgling is not only heard but felt and where it ceases, the limit of the cæcum may be fixed. An exception to this is Asiatic cholera in the asphyxiated stage, when neither the cæcum nor other sections of the colon can be palpated. In typhoid fever the cæcum is dilated, its resistance is heightened, and it is sensitive to pressure. Palpation of the cæcum usually produces gurgling sounds, which point to the presence of gases and fluids. The palpation of scybalæ hints at pathologic conditions interfering with peristalsis and absorption. The cæcum can be mistaken

for a kidney which has floated into the region of the cæcum and has become fixed there through adhesions. Its smooth, bean-shaped form and its pulsation at its hilum, makes it easily recognizable. It may also be said that the kidney is extraperitoneal. If the colon be inflated, the kidney which lies behind it is likely to disappear. In cases of ptosis of the transverse colon, mistaken identification may also take place. The cæcum is best recognized by its circular end, while again a continuation beyond the median line can be ascertained in the transverse colon. It is possible also in such cases to find the cæcum on the outside of the transverse colon (11). Sometimes a part of the ileum is taken for the cæcum, but the diagnosis can be established by palpating the curved border of the cæcum; the ileum disappears at the border of the pelvis.

Palpation of the ascending and descending colon is very uncertain, as loops of the small intestine lie in front of them. Localization of the hepatic flexure of the colon is also difficult, inasmuch as it lies somewhat behind the liver. The splenic flexure can be determined more easily, a circumstance which is quite important in practice. This segment, when full, feels similar to that of the spleen. It is found at the left lower border of the thorax, in the region of the spleen, and in the left, upper back, of the abdominal cavity.

The transverse colon lies usually immediately beneath the large curvature of the stomach; when the position of the latter varies, a like variableness in the position of the transverse colon takes place. In general, it may be said that in the average man the transverse colon is one centimeter below the umbilicus. The section of the transverse colon which is accessible to palpation has either a horizontal direction, as is the case when the transverse colon is high, or it is bow-shaped with the convexity downward. It is quite rare to find that both parts of the bow, right and left of the median line, are exactly alike. Usually the right half is more horizontal, while the left rises somewhat abruptly from the median line. Sometimes the transverse colon takes the form of a Roman V. In palpation of the transverse colon we can sometimes produce loud gurgling sounds which point to the presence of gas and fluid. This has been observed after taking laxatives, in various kinds of diarrhœa and in typhoid fever. On the other hand, a cylinder which feels somewhat firm without gurgling is found in chronic colitis. The transverse colon is felt in most cases as a soft rope; under pressure low gurglings are heard; these suggest pulpy contents mixed with gases. Palpation of hard scybalæ in the transverse colon is rare, and, just as is the case of the cæcum, points to modifications of the peristalsis of the large intestine. If scybalæ are felt in the transverse colon, they are found to exist not isolated, but in large numbers, and at the same time they exist in other segments of the colon.

The position of the transverse colon depends on the position of the large curvature of the stomach, and it has a corresponding freedom of movement during respiration. The higher the colon lies, the greater the intensity of its movements during respiration. The passive mobility of the transverse colon is very great. In palpation it can be moved without difficulty upward and downward three to four centimeters. The consistency of the transverse colon changes often without regard to its contents; it may at first feel firm, and become soft while still under manipulation, and at times it may even disappear under the palpating fingers. This may be explained as a purely physiological phenomenon, in contradistinction to contractions seen in intestinal stenosis or obstruction of the bowels accompanied by cramp-like pains. The palpation of the transverse colon is made easier through its superficial position and

relation to the stomach. In emaciated patients it is marked by sharp outlines. If, in consequence of continued atony, it has become a wide, loose sack, it may be mistaken for a dislocated stomach. In palpating it at the height of the navel, we feel about the breadth of the abdomen an extensive festooned arched organ of the consistency of an air-pillow, which can be easily isolated by the hands from the other organs. It can be differentiated from the stomach by dilating the latter artificially with air.

The sigmoid flexure should be palpated in the left inguinal region, and also in a perpendicular direction above the middle of Poupart's ligament. The investigation of the sigmoid flexure is quite easy. It feels like a cylindrical rope, moderate in consistency; no gurgling sounds are produced during palpation. Though gurgling is observed in various diseases of a diarrhœtic character, after laxatives, in typhoid fever, etc. In these cases the sigmoid flexure is dilated. In dysentery the sigmoid flexure is felt as a solid, thick cylinder, is painful under pressure, and no gurgling sounds can be produced. The contents are usually mushy or fluid, as in diarrhœa. In chronic constipation scybalæ may be felt occasionally, but fæcal matter can be easily recognized in the sigmoid flexure as smooth spherical or cylindrical masses which yield when pressed toward the back of the pelvis. The sigmoid flexure often has peculiarities of the same nature as those of the transverse colon. At the cessation of the diarrhœa the sigmoid flexure may be reduced below its normal size, assume a ropy form without the production of gurgling sounds, and become as thick as the thumb or index finger. But when by palpation we find that the transverse colon or cæcum is enlarged, considerable gurgling is produced in the sigmoid flexure. We may often find the sigmoid flexure without feeling the transverse colon; but, on the other hand, we can not feel the colon transversum without at the same time feeling the sigmoid flexure; there is but one exception, and that is a stricture of the colon in the neighborhood of the hepatic flexure. Easy palpation of the sigmoid flexure in adults is a normal phenomenon. Where the sigmoid flexure can not be found, we may be certain that there is some cause for the difficulty, as for instance where there is a hernia within the abdominal cavity. It is possible that the sigmoid flexure may be taken for a depressed transverse colon. The latter is recognized by the fact that it can be followed several centimeters beyond the median line, while the sigmoid flexure disappears into the pelvis. Ptosis of the transverse colon is also frequently taken for the sigmoid flexure, but the latter can be traced as proceeding from the pelvis outward. Quite frequently it is found that the sigmoid flexure lies above the pubes and adjoins directly the abdominal wall, assuming the form of the Greek omega. Such a position of the sigmoid flexure is clinical.

So far as the diagnosis of the seat of carcinoma and other tumors is concerned, palpation will give valuable data, for the reason that we ascertain the mobility of the tumor and refer it to a definite location.

A strangulated section of the intestine becomes frequently recognizable by its dilatation and immobility at a circumscribed spot, disclosing itself through stronger resistance to palpation and asymmetric forward arching in inspection.

In intussusception we can prove in fifty per cent. of cases the presence of an enlargement in the abdomen which can be found in children more clearly and more easily than in adults. The tumor is usually smooth, hard, cylindrical and irregular; its compass varies from the size of an egg to that of the fist of a man; and sometimes it goes to the length of the

forearm (12). Not infrequently it becomes noticeable in paroxysms of pain only, and escapes the hand of the palpator in the intervals. Most constantly the evidence of enlargements is present in ileo-cæcal and colon invaginations. Where a tumor is present it may originate in an ileo-cæcal invagination which can be readily found in children; it does not lie then in the region of the cæcum but in the part above and to the left of the umbilicus, which corresponds to the transverse and descending colon.

In tuberculosis many palpable tumors are recognizable. These may be due to the enlargments of the mesenteric glands.

We must not forget that the results from palpation may vary in successive examinations, inasmuch as the perception of certain enlargments may vary. In fact tumors have been known to disappear transiently, and may be perceived again after the lapse of some time.

In conclusion I wish to say that in presenting this paper I do not wish to be misunderstood as claiming for palpation that by it alone we can diagnose disease, but rather that it should be employed as one of the many other means at our disposal to arrive at the correct conclusions.

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**Hysterical Hip Disease.**—Dr. James Putnam, writing in the *Journal American Medical Association*, makes some interesting comments on this malady. He says that absolute increase of measurement from the anterior superior iliac spine to the internal malleolus is a sign of hysterical hip disease. "The differential diagnosis between tuberculous and hysterical hip disease is sometimes easy," writes Dr. Putnam, "but sometimes very difficult, while a correct diagnosis is always of great importance. Whereas in tubersulous disease the erosion and absorption of the bone shortens the measurement from spine to malleolus, in hysterical hip disease this measure is sometimes longer on the affected side. The explanation of this was given by Halsted—namely, that the affected leg is abducted in hysteria, while the opposite leg with which comparison is made, is abducted. The pelvis is literally tilted in such cases, and is probably due to the contracture of the muscles of the affected thigh. The presence of other symptoms characteristic of hysteria will confirm the diagnosis. These, according to Gilles de la Tourette, include pain and tender spots of various points along the affected limb, marked cutaneous hyperæsthesia, absence of nocturnal paroxysms, the presence of hysterical œdema about the affected joint and limb, involvement of the knee muscles in the rigidity, coldness of the affected parts, and the presence of fits and the mental "stigmata" of hysteria. In a patient aged 30 years, who fell through a trapdoor and struck her hip and the back of her feet on the floor five feet lower, the symptoms of hip disease, with contracture and hyperæsthesia, and pain on passive motion were present. The attitude and measurements corresponded with those of hysterical hip disease, and hemianæsthesia was also noticed. Œdema of the hip persisted for a long time, and the entire left leg was cooler than the right. The knee-jerk and plantar reflex was also exaggerated in this leg. On examination under ether, the differences disappeared, the movements of the hip-joint were free, the measurements normal, and the feet and whole appearance of the two hips became essentially alike on the two sides."

## VACCINATION AND CHICKEN-POX.*

BY E. S. SHERRILL, M. D.,
Detroit, Mich.

The following case presents an interesting and unusual coincidence, the occurence of chicken-pox and vaccination in the same patient at the same time.

E. P., aged four years, was vaccinated as a precautionary measure at the time of her father's illness with chicken-pox, January 25, 1902. On February 4, 1902, with evidences of the vaccination taking in the normal way, the child developed chicken-pox, which progressed in a typical way. Two other children besides the case referred to contracted chicken-pox, the eruption appearing with them on February 1, 1902. The eruption in the case of the vaccinated child was far less pronounced than in the other children, in all not more than twelve vesicles developing.

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## THE MEDICAL TREATMENT OF GALL-STONES.*

BY E. S. SHERRILL, M. D.,
Detroit, Mich.

From time to time the medical Journals discuss the desirability of more careful attention to the medical treatment of gall-stones. During the past year my treatment of a case, in which an operation was not advisable, has given such satisfaction that I wish to call the attention of the profession to it. While I have just used the expression, "my treatment," there is no claim of originality intended. Dr. Buckler, of Baltimore, (*American Journal Med. Science,* July, 1867) advocates the use of succinic acid and peroxide of iron on account of the large amount of oxygen contained in them. They are combined and given in the following prescription for six months at least:

℞ Hydrate Succinate of Peroxide of Iron, oz. 1½
Distilled water, oz. 8
M.
Sig. Teaspoonful after meal.

The use of this remedy is commended by Octerlony, of Louisville (A Paper on Chole-lithiasis, 1877). In this paper the writer says: "I have used this salt according to this formula and in almost every case with complete success." This authority advises at the same time a course of Carlsbad water.

The case in which I have employed the treatment now for more than four months is that of Mrs. C., aged 47, who for two or three years has been subject to attacks which could be diagnosed ordinarily as gall-stone colic. The attacks would begin with decided discomfort in the epigastrium. This would be followed by vomiting and pain. After some of the attacks the patient would be jaundiced. The attacks had become more and more frequent and were occurring every two of four weeks. After administering the remedies referred to, the succinate of iron and the Carlsbad water, the attacks soon became less severe and now for four months have ceased entirely. The patient is very grateful.

The prescription is one which may be had of any druggist.

270 Woodward Avenue,
Detroit, Mich.

*Written for the Detroit Medical Journal.

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**Cleanliness.**—"If I were asked to name the single factor of greatest moment to the hygiene, the attractiveness, and the comfort of a hospital ward, I should unhesitatingly say cleanliness; cleanliness in the ordinary sense of the word as understood by every good housewife. Not only cleanliness of the ward and its furnishings, but cleanliness of the patients, of the nurses, of the attendants and of the doctors. Without cleanliness all the elaborate rules, regulations and opinions on ward construction and management mean nothing in so far as satisfactory results are concerned; with cleanliness as the watchword it is often astonishing what can be accomplished even in hospitals devoid of the commonest conveniences of model institutions."—(Dr. A. C. Abbott, in *Pennsylvania Medical Journal.*)

## ELECTRO-THERAPEUTICS.*

Clinical Lecture by
ORVILLE W. OWEN, M. D.,
Detroit, Mich.

I shall divide my subject into four heads and cite one or more cases under each subdivision.

Believing as I do that failures teach to the student as much as and even more than success, I shall mix success and failure together. In other words, I shall try to give a true series of experiments in my electrical work. The subdivisions I have elected to use are:

1st. Peripheral manifestations.
2nd. Central manifestations.
3rd. Special manifestations.
4th. Tumors.

It has been my good fortune to have had sent me for treatment a number of seemingly like conditions: but under examination and treatment marked differences have appeared and complications that have very materially changed the results, as the two following cases will show:

Mrs. A., aet. 29. White American, married, no children. Temp., normal, pulse 78, respiration 19, weight 140; mixed type, well-to-do, no specific history. She was suffering from facial paralysis of the right side, of four days' standing, which had come on quite suddenly without premonitory symptoms. Physical examination revealed loss of sensation in lower portion of the face. Marked hyperæsthesia of supraorbital nerve. Tongue deflected to left, partial loss of taste and smell. Ptosis nearly complete. Muscles of the eye slow in action: dilatation of right pupil.

The patient was requested to seat herself in front of the static machine and then a ball electrode attached to the anode was slowly carried down the back, beginning at the base of the neck. Sensation was normal until the second dorsal vertebra was reached, when no spark was felt. The prime conductors were then cautiously drawn apart until a four-inch spark was administered, when a slight sensation of burning was manifested. The second, third and fourth dorsals were anæsthetic; below normal, sensation again became apparent.

The patient now remembered that twelve years before she had been thrown from a carriage and badly bruised at this point.

Believing that the trouble came from this, treatment by spark and galvano-faradic currents were used daily along the back, with faradization of the seventh, fifth and supraorbital nerves. At the end of twelve treatments the paralysis had entirely disappeared, the dorsal nerves responded to a half-inch spark, smell and taste were normal and the patient was discharged as cured. I saw her within the last ten days and there had been no recurrence of symptoms in the five months since she was treated.

The next case is one of absolute failure. Mr. B., a patient sent me by Dr. Hickey. Facial paralysis left side, history of specific infection. All the physical signs of paralysis were marked. Back responded to spark normally. Six mixed treatments were given without in the slightest degree affecting the trouble. The static spray failed to open the capillaries, nor would the galvanic current show any marked variation of blood pressure.

The natural deductions to be drawn from these two cases are: First, that non-specific lesions are amenable to electric treatment: Second, that careful resistance measurements by spark and galvanometer should be used in every case.

The next case was Mrs. C., sent me by Dr. E. L. Shurly. Paralysis of the flexor muscles of right forearm; unable to dress herself; pain sharp and lancinating. The trouble was of three months' standing. Upon examination the muscles responded slowly to the interrupted galvanic current, when the interruptions were eight

*Delivered before the Detroit Medical Society.

to the minute. Faradic current increased the pain. The back was normal.

The treatment consisted of static spray for 15 minutes, applied to the head, and galvanic massage with a 15 milliampere current to the flexor muscles for from 10 to 12 minutes. At the end of thirteen treatments the patient was discharged cured, and now, nine months from the time of the treatment, there has been no recurrence.

Mr. D., aet. 19, sent me by Dr. Inglis. Paralysis of the right wrist; unable to write, put on his gloves or feed himself. There was history of a sprain four months before. All the muscles of the forearm were slow in responding to stabile or interrupted current. Treatment, galvano-faradic massage full half-hour daily, with cataphoresis of potassium iodide twice a week. At the end of sixteen treatments patient was discharged cured. No recurrence.

In central disorders, I shall report only two cases.

Mr. E., patient sent me by Dr. Inglis. Locomotor ataxia, involuntary passages of bladder and bowels. No history of specific trouble, but had been a masturbator for a number of years. The patient was aet. 49, but looked 70. Treatment by indirect spark, nine inches long. The involuntary passages ceased at the end of eight treatments. The patient was able to stand upright, but the locomotion was not in any way benefited. The case was one of twelve years' standing and even the help given in the matter of cleanliness and absence of odor was of great benefit.

Mr. F., patient sent me by Dr. Charles D. Aaron. Yosemite victim; nervous depression from the cruel treatment upon that sink of cruelty during the Spanish war. Anæsthesia of spinal nerves, marked tendency to fall asleep and great irritability when aroused. No history of syphilis or gonorrhœa. Did not drink and was only a moderate user of tobocco. Treatment was directed to spine and head. Static spray and spark 15 minutes, with a 5 milliampere galvanic anode to the spine and a cathode plate over abdomen. After twenty-six treatments the patient was able to go about his duties and was later sent to Paris by his employer. A letter recently received from him states that he is in good health and spirits.

Special manifestations:—Mrs. G., patient sent me by Dr. Lennox, married, the mother of one child. Hyperæsthesia of vagina, intense pain at coition. No caruncles or enlarged glands. Back normal. Treatment by the vaginal electrode, 15 to 20 milliamperes positive galvanic current, abdominal plate. The patient was relieved from the start and was cured after ten treatments.

Mrs. H., patient from the interior of the state. Mother of one child. Enlarged left ovary. Painful to the touch; had to wear loose clothing; walked with difficulty. Treatment, large abdominal plate over ovary, negative pole saturated in iodide of lithium. Positive carbon electrode introduced well up the vagina. Twenty-five milliamperes galvanic current slowly applied for 5 to 7 minutes. Cured in nine treatments. Perhaps in all the work done by the writer, there has been no one case so pronouncedly marked in relief as this one. I have received a letter from the patient in which she thanks me over and over again for the complete cure effected without removal of the ovary.

Tumors:—Mrs. N., married, mother of three children; aet. 47; epithelioma of the uterus and abdominal wall; two prominent surgeons had refused to operate and the patient was given but a few weeks to live. She was brought to my office in a carriage and caried into my room. A carbon electrode was introduced into the vagina and a spongio piline plate applied to the abdomen. A 35 milliampere current was used on the anode for seven minutes, and the patient was sent home.

One week from that day she came again; a slough as large as a small orange had taken place and the introduction of the electrode was much more easy. A 45 milliampere current was used and this resulted in a large slough. At the end of a week the patient came to my office on the street cars and without help. A 65 milliampere current was used, again resulting in a slough that allowed me to introduce a platinum uterine electrode, and then the current was increased to 75 amperes for five minutes. My patient was up and about the third day after the treatment and walked to church. The next day for treatment being stormy, a carriage was called and the patient and her friend started for the office. The coachman was drunk and the horses ran away, with the result that when the patient arrived at the office she was in a state of collapse from which her weakened condition did not permit her to recover. She died four days after.

I have murmured somewhat against fate in this case, as I am not sure but a cure could have been accomplished. Perhaps fate was kind to me, but for all that I could wish that something would happen to that drunken driver.

Another patient was Miss O., white American, aet. 39. Hard lump in the left breast, lancinating pains; no enlargement of the glands; tumor diagnosed by another physician as carcinoma. Treatment, stabile current with mercuric catophoresis 25 milliampheres negative pole to abdomen; positive pole, carbon electrode to tumor. In eleven treatments the growth disappeared and there has been no recurrence to date.

This closes my citation of cases. I have tried to show both success and failure and I believe I have done so. It would have been easy to have shown nothing but success; but if one cure any and all he would be divinity and not mere man. From failure comes knowledge; from absolute success comes egotism. But there are enough failures to keep down the rising "I Am." Whatever may have been the prejudice against electricity in the past. it is rapidly disappearing under the light of the Roentgen ray and the static spark. And the new century will, yea must, show gigantic strides in electro-therapeutics. New machines, new electrodes, new methods and new men will carry the science upward until there will be no other single agent so much used, in my belief, so universally successful as electricity.

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**Congenital Absence of Abdominal Muscles.** — Osler, in the *Bulletin Johns Hopkins Hospital,* reports a third case of this rare condition. Parker, in the *Clin. Soc. Trans.,* Vol. xxviii, 1895, and Gutherie, in the *Pathological Society, London, Trans.,* Vol. xlvii, are the only other anthorities who have contributed reports to the literature. Osler's case is as follows:

"The child was well until the second summer, when gastric attacks of nausea and vomiting began. From the history of the case, in some of the attacks the chief trouble was with the urine. The spells lasted four or five weeks at a time. The present crisis showed pains in the abdomen and burning upon urination. The very weak, anæmic, poorly nourished child complained of pain in the hypogastric and lower umbilical regions; passed urine fifteen or twenty times daily, and had a temperature ranging between 99° and 102° There was remarkable fullness in the hypogastric and lower umbilical regions, with an ovoid mass corresponding to a dilated bladder. In the recumbent position the belly flattened out in front and extended in the flanks. Coils of intestines could be seen in peristalsis. There was extreme relaxation of the abdominal walls and the organs underneath could be easily palpated. It was possible to feel the whole extent of the liver. The bladder reached almost to the navel. He has cryptorchidismus."

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EPITOME OF PRACTICE AND THERAPEUTICS.

WALTER C. BOYNTON, Manager.

—ISSUED BY—

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## OSTEOPATHY.

The state of New York is apparently getting after osteopathy with a sharp stick, if the press dispatches are to be believed. Sens. Brackett and Krum are quoted as being the only members of the state legislative body who favor the Missouri method of healing, while their favor itself is practically confined to a willingness to report favorably on a bill to provide for the creation of a state board, whose province it shall be to examine osteopathy with a view to seeing whether or not they are fitted to ply their vocation. Most states now have similar boards for plumbers, horseshoers and undertakers.

The physicians of the Empire state were present in somewhat large numbers at the legislative meeting at which osteopathy could muster so small a showing of hands, and spoke vehemently against any bill which provided for the admission to practice of oesteopaths. From an ethical standpoint, perhaps they were justified in their denunciation; from a selfish one, they were unwise. It is reasonable to assume that osteopaths treat people because people want to be treated by osteopaths. Even the fiercest opponent of osteopathy has never pictured the osteopath as literally cramming his treatment down the throat or into the flesh of an unwilling and protesting patient: they are probably called in attendance by the patient just as reputable practitioners of medicine are. The people, then, who patronize the osteopathic gentry are largely to blame.

And after our osteopathic friend has tried and failed, the patient comes to his senses, dismisses the rubber-man and sends for a physician. Perhaps the latter fails, also. But it is much more probable that his failure, if any exist, is due to the fact that the patient's constitution has been worn threadbare under the hands of the osteopath. Osteopathic "cures," of which adherents of the cult prate so loudly, are much like those of Christian Science, extremely hard to locate with any definiteness or assurance that the recovery of the patient was not made in the face of Christian Science, or osteopathy, rather than by its aid.

So long as people are credulous and ignorant of some of the most fundamental principles of health and right living, the osteopath and fellows of his kidney will flourish in the land. Detroit has had numerous experiences in seeing the establishment of "magnetic institutes" on her prominent residence streets and members of the medical profession have had the chagrin of seeing the carriages of wealthy and presumably intelligent people—standing in front of the "professor's" door. Money comes easily to anyone but a reputable practitioner. But the next chapter of the professor's career is quite likely to be his appearance as defendant in an assault case, the charge being a "laying on of hands" not authorized even by whatever rules his profession may have. We have seen several cases of this kind in the city, and the wonder is that refined women will submit to being pawed over by some ignorant fellow who has never received even an average education and whose instincts are those of an animal. No one knows how many cases of abused confidence there have been, kept secret by the patient through a natural horror of figuring in any such connection before the court. But the

"layer on of hands" continues his blasphemous pretensions and secures his patients by the score for a time. Then he is driven out by his landlord because he refuses to pay an honest debt—and he departs to another town, changing his name as easily as he does his clothes. Another establishment is set up and the same performance gone through with.

It seems to be clearly the duty of a governing body to frame such laws as shall shut out from "practice" such persons, failing the ability to educate the people at large to better ideas concerning the sacredness of the medical profession, which is truly one of the three-fold gospel.

### DR. IMMANUEL PFEFFER.

A Boston physician, named Immanuel Pfeffer, is reported in the Associated Press dispatches as being ill at the home of his son in Weston, Mass., suffering from small-pox. This statement in the daily press might not attract more than passing notice, were it not for the fact that the physician in question has been more or less prominently mentioned as an opponent of vaccination, on the ground that it is unnecessary. So thoroughly convinced was he of the uselessness of vaccination that he secured entrance into one of the city hospitals some three weeks ago, on the ground that he had a right there as a practicing physician. His exposure to the disease of small-pox in the ward devoted to the treatment of that malady was complete and satisfactory and if the experimenter had escaped the disease there might have been strong grounds for the belief that there was something in his statement that he could not contract it.

The fact that he did contract what had every appearance of being a complete and virulent case of small-pox, however, goes far to disprove his contention. He was removed to the home of his son and information is given that his retirement from the city in which he had formulated his theory was in a way sudden and secret. Certainly he made no effort to call the attention of his brother practitioners to the fact that he had contracted a disease which he had stated time and again was impossible to contract. He hoped to prove by his exposing himself that vaccination was unnecessary and in fact was not far from being a myth. The untoward result will go far to convince the profession and the laity as well that Dr. Pfeffer's theory was lacking in some of the essentials of a tenable one: and if the disease should have a fatal termination, there will be little debate as to whether the doctor sacrificed himself in the interests of science or on the altar of obstinacy.

## EDITORIAL NOTES

**Amœbic Dysentery in Children.—**

The *Journal of the American Medical Association,* speaking of this malady, makes the following comment:

"In a recent contribution to the subject of amœbic dysentery in children, Dr. Samuel Amberg has added very much to the clinical knowledge of the disease. Besides the four cases of Harris, he refers to two others which have been observed in the United States in which the amœba was demonstrated in the fæces, and he adds five cases observed by himself, occurring in the service of Osler. His cases were from two and three-quarters to five years of age. Following the classification of Harris, four of the cases belong in the group of the very mild form; there was little effect on the appetite and general health and the stools varied from two to six in twenty-four hours, with no fever or acceleration of the pulse worth

mentioning. Harris had referred to this form as the usual one in children, and the small amount of discomfort experienced by the children is a striking feature. Amberg's fifth case belongs among those of moderate severity. In two cases, prolapsus recti was observed. No hepatic complications were present in any case, and amœbic abscess of the liver seems to be very rare in children as compared with adults. Amberg was able to find but twelve cases in the literature where abscess of the liver followed dysentery in children, and in only two of these were the amœbæ demonstrated. The symptoms correspond closely to those in adults. The fæces may be formed with bloody, mucoid masses on the surface, or there may be loose passages, containing more or less blood and fragments of mucous. The diagnosis was always based upon the finding of motile amœbæ containing red corpuscles in the fæces.

"Charcot-Leyden crystals in fæces have often been referred to by writers upon amœbic dysentery, and their presence in the fæces of persons suffering from helminthiasis is well known. They were present in four of Amberg's cases, and with them were always associated eosinophile cells and free eosinophile granules in varying abundance. Because of the inconstancy of the picture of the fæces, Amberg is unable to draw a conclusion regarding the relation between the numbers of amœbæ, crystals and eosinophile cells. In any case, Charcot-Leyden crystals in the passage of a child should always excite a suspicion of amœbic dysentery, and this is of especial importance, as the amœbæ may be found only after repeated examinations. The significance of the eosinophile cells must be determined by further study. Now that attention has been called to the subject by a series of carefully studied cases, we may expect further observations upon similar cases in the near future. The accurate diagnosis is of much importance from the side of treatment, as injections of quinine solutions appear to be most efficient in combating this variety of dysentery."

(Has any reader of the *Detroit Medical Journal* had any case of amœbic dysentery come under his recent attention? We should be glad to publish a detailed account of its progress.—Ed.)

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**Quackery in Pennsylvania.—**

Dr. Harry Hakes, of Wilkes-Barre, Pa., read a paper before the Luzerine County Medical Society, in which he deals some sledgehammer blows at irregular practitioners. The society has reprinted Dr. Hakes' paper, portions of which follow. As it is in line with the editorial of this month's issue, it may be of interest.

Dr. Hakes said in part: "Restrictive medical legislation is a failure in Pennsylvania; nay, more, it opens up schemes of fraud in the examining board. The law is a dead letter by common consent. Only last week a bill designed to restrict irregular practice in New York was before a committee, and the rooms were packed by faith curists, Christian scientists, spiritualists, prayer curists, etc., with able legal counsel to protest against legislation inimical to their pretensions. For a wonder, the osteopathists are not mentioned as present at the scramble. I have never had much faith in medical legislation in restraint of quackery, and if I ever had, I confess it has become attenuated to the remotest degree. Well, we are not likely to behold the termination of medical quackery, or such a universal diffusion of pertinent knowledge as shall prevent the generality of mankind from chasing after strange gods, or submissively yielding to the alluring pretentions of the charlatan and pretending healer. But the question is pertinent, who will be your allies in this endless competition with ignorance, fraud and imposture? Certainly not those from whom

you might reasonably expect it. Where will you find the members of that learned profession, the Bench and the Bar? Generally as ignorant of the issue as the common uneducated laity, and when and where they could do you the most good, they are more than likely to cast their influence against you. It is true you can purchase the services of the Bar, in your behalf, but they are just as free to serve your opponents for pay also, and a little more so, because it is a great thing, before a public audience or court, for the lawyer to outgeneral and degrade the doctor, if possible. Medical imposters are not necessarily fools, and are not slow to parade the names of the judiciary, certifying the virtues of their wares. But what of that other learned profession, the theologian, or the clergyman? Their influence is scarcely neutral, for the reason that they also may make some claim, quite unquestioned, of ministering to alleviate human suffering—if not the physical body, yet to the mind of the sufferer—nor is it right to ignore or depreciate this aid to the doctor.

"What a lowering of the dignity of a learned theologian is this. Hear what the Rev. Mr. Small says:

'My wife, myself, and all our numerous children have long been suffering from asthma, diabetes, sick-headache, strangulated rupture, typhoid fever, nervous prostration, cancer, scrofula, and all the various gynecian complaints known or unknown. Tried all the doctors, but got no relief. When we were all about gone up, we tried one bottle of the blessed Lydia Pinkham's sovereign "ready relief," and we are now about as well as usual. Praise God from whom all blessings flow.

Rev. Giasticus Small.'

"One of the most transparent frauds of any era has recently been launched hereabouts, christened *"Osteopathy,"* in which it is claimed that human beings are merely machines, and their diseases can be cured by mechanical means alone, without drugs, medicine, or the use of any surgical instruments, the same as a locomotive or a watch. If man were only a machine, this theory would be true. But the fact remains that man is more than a machine. Man is an organism; he is begotten of his kind, he grows, he has life, he possesses will and reason. Of his own volition he goes from place to place; he talks, walks, can laugh or cry, can strike and kick. He is imbued with a spark of the Spirit Eternal; he can love and beget his kind. I have no words to sufficiently express the foolishness or degradation of one, elaborated from the economy and workshop of Jehovah, who realizes in himself nothing but a senseless and soulless machine.

"Such nonsensical philosophy can no more live and endure than could a man without a head, heart, stomach and lungs. So, too, will soon pass the horse doctor's scheme of mechano-neural therapy.

"There are other forms by which ignorance, superstition, imposture and avarice are presented as friends of suffering humanity, supposedly screened and entrenched behind the bulwarks of the religious sentiment, or religion itself. Of course you at once recognize that I refer to so-called faith curists, prayer curists, alleged divine healers, etc., all somewhat agglomerated under the specious and awe inspiring name of Christian Scientists. The insidious danger that lurks unseen in their theories and practice, is that the religious sentiments are appealed to in support of modern miracles—upon a strictly cash basis.

"Quackery in all or any of its cunning forms has its foundation in gross superstition, or in selfishness, ignorance and greed, and first or last is self-explosive. Stamp out all its multifarious forms today, if you please, or if you can, but you may rest assured that as long as ignorance, superstition and selfish greed pertain to men, and women too, quackery

under some possible guise will reappear and find an abundant clientage of asses and dupes to pay for, advocate and defend it. Keep this in view constantly, that you do not underestimate the number of people, who, in need of skilled labor, are astute enough to seek those who are best educated and practiced in their particular business, but if it is a case of disease to be treated, unwittingly reverse their tactics, led astray by the pompous advertising of the charlatan, the ignoramus, the hypocrite or scoundrel who depletes their cash, and in course of time enables them to report that he or she is about as well as usual. The quacks do not seek their customers among those attacked with acute ailments. They seek what are called "hypochondriacs" and "chronic cases," not because they can cure them, but because they want a staying and long paying customer. As long as quackery claims to treat disease by physical and visible means, you can well afford to leave it severely alone. Yea, give it all the rope desired, and contain your souls in peace. But when claim is made to cure diseases by occult power, by invisible means, by Almighty power, summoned at the will of a miserable shyster, male or female, for filthy lucre, then and there draw the line on all such and their abettors."

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In the January number of the *Detroit Medical Journal*, on page 315, appeared a short and pithy item, headed "Suggestions in Male Urethra Work." It was credited to Dr. Keller, but further credit should have been given to the *Medical Council* of Philadelphia, in whose January number it appeared. We hope Dr. Taylor will pardon the oversight, for it *was* an oversight, and that he will unite with us in an earnest effort to give credit where credit is due. Some of the other medical publications ought to join in, also.

Among the recent visitors to this office was Joseph Milkowski, possibly better known as Edward Lewis, the "man with the musical heart," as he is called. Lewis is an interesting study from the point of view of the physician: his heart was wounded by a sabre thrust at the Yarkautz gold-mines in Siberia in 1889, while Lewis and his companions were trying to escape a sentence of life imprisonment as punishment for the Nihilist attempt made on the life of Czar Nicholas III in 1885. When the prisoners escaped, they were overtaken by the Cossack guard and and in the melee Lewis was stabbed. A German physician told him the wound was fatal, but by some chance the victim recovered and later, when he was in the hospital it was discovered that his heart gave out most unusual sounds, resembling those of a wind-instrument.

Since that time, Lewis has been a more or less familiar figure to the medical profession of the country. He travels extensively and permits examinations of his heart by whatever means the physician thinks wise: he naively remarks that he does not want his heart cured, as it is now his means of livelihood. The Roentgen ray shows that the organ is nearly three times the normal size, but in spite of this fact Lewis appears to experience no inconvenience from it. He has on several occasions made arrangements with physicians to have his heart go at his death to some educational institution, but up to the present he has always outlived the man with whom the arrangement has been made.

The present condition of his heart is most interesting, and he has hundreds of testimonial comments on it from prominent men in the profession.

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A committee of the College of Physicians of Philadelphia has announced that the sum of $500 will be awarded to the author of the best essay on "The Rela-

tion between Chronic Suppurative Processes and Forms of Anæmia." This sum of money is from the Nathan Lewis Hatfield prize for original research in medicine, and a few simple conditions are imposed by the committee upon those who compete for the prize. All essays are to be submitted before March 1st, 1903, each essay to be typewritten, designated with a motto or device, and accompanied by a sealed envelope bearing the same motto or device and the name and address of the author. The only envelope to be opened will be that accompanying the successful essay.

In accordance with the conditions of the Trust, the treatment of the subject must embody original observations on researches or original deductions; the committee reserves the right not to make the award if no essay submitted is considered worthy of the prize. The competition is open to all members of the medical profession and men of science in the United States.

The original of the successful essay shall become the property of the College of Physicians and its Trustees shall have full control of its publication. It shall be published in the Transactions of the College and, if thought expedient, as a separate issue. Unsuccessful essays shall be returned to their respective writers or their agents if claim is made for them within a year.

Competitors should address J. C. Wilson, M. D., chairman, College of Physicians, 219 S. 13th St., Philadelphia, Pa.

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**Surgeon and Druggist.—**

Vol. I, No. I, of the "Surgeon and Druggist," published by the J. Ellwood Lee Co. at Conshohocken, Penna., has been received. It is a neatly gotten up pamphlet of sixteen pages, whose object, stated in its greeting, is to "represent advanced modern ideas in the general science of healing." The present number contains some interesting excerpts from the best journals and has also a report on a successful formaldehyde disinfection test carried on by A. W. Clark, the chemist and bacteriologist of the company.

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**In Gastric Flatulence.—**The sulpho-carbolate of sodium will be found highly beneficial in such trouble. In the gastric form the drug may be given in aqueous solution (gr. v to x) after meals, and where constipation exists, as is so frequently the case, the aromatic fluid extract of cascara sagrada may be advantageously added. In the intestinal form of flatulency the sulpho-carbolate is best administered in pill form (enteric coating) in which instance two and a half or four grains may be used.—(*Clinical Review.*)

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**Stone at an Early Age.—**Dr. M. F. Porter, in *Annals of Surgery,* gives the folfowing data in the case of a child less than four years old: "The attacks were for a time considered of intestinal origin and later, after careful inquiry and observation, of renal origin. Soon after this stones were passed with the urine. The trouble began when the baby was only six months old; during the next two years she had a great deal of trouble of the same kind and passed in all perhaps a teaspoonful of stones, ranging in size from that of a millet-seed to that of a large grain of wheat. The attacks ceased and for a while she seemed to be without trouble. When about four years old the patient was seen again and it was learned that for some days while passing urine she had had attacks of pain in a way to suggest stone in the bladder. Under sounding the diagnosis was confirmed. The operation was done two days afterward and the stone removed by suprapubic cystotomy. The stone weighed when thoroughly dry sixty grains and measured seven-eights of an inch in width and three-eights of an inch in thickness. The bladder was immediately sutured with catgut and the external wound with silkwormgut and a small wick of gauze left in the lower angle of the wound. This was removed in forty-eight hours. The bladder was drained for five days with the retention catheter and the child was discharged from the hospital on the 12th day of April cured. At the time of operation she was three years ten months and twenty-five days old."

# New Instruments & Devices

## NEW SYRINGE.

Rotary Spray syringes are not entirely new, but for the one illustrated herewith some extra advantages are claimed. It is made entirely of rubber and the soft rubber shield is sufficiently yielding to secure an absolute fit to the parts, doing away with the possibility of leakage. There are no metal parts to corrode and no valves to get out of order, while its simple construction makes it possible for the manufacturer to sell it cheaply.

The syringe throws a hollow, rotating mass of water, whose action is thoroughly cleansing. Injection and suction combine to cleanse the parts. The syringe retails to the profession for $1.50.

## INDEX RECORD.

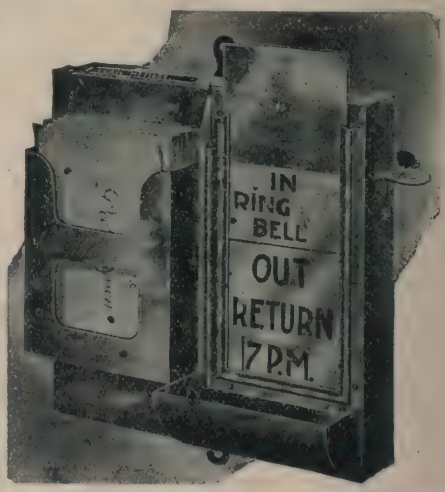
The methodical physician ordinarily likes to keep a pretty careful record of the cases under his treatment and the outfit illustrated herewith will be of great assistance along these lines. Cards suitable for historical data are provided, with spaces for name, age, nationality, weight, temperature and so on, a special arrangement being provided for the easy in-

sertion and removal of the cards in the box without disturbing the other cards. The size of the cards is 4x6, ample to allow brief history of each case. Another set of cards allows the writing of historical data on the back and on the face are spaces showing date, treatment, fee—if any—credit, and other interesting and practical things. The name and address of the patient are placed at the top of the card and alphabetical arrangement permits of easy inspection by the doctor, who can inform himself at a glance of the history of the patient's case and the indebtedness of the patient at any given time. The whole outfit is neatly put up and enclosed in a handsome polished box.

The price of the complete outfit mentioned above is $8.50, and the same company puts out a special trial outfit for $3.50, which shows the advantages of the system.

## THE BELL BOY.

The acompanying cut shows the "Bell Boy," a recently designed device for the use of physicians. It is five inches square and is intended to be placed at the side of a physician's door, answering the purpose of a bell boy. A small metal slide with a handle can be made to assume two positions, one showing the legend "IN, Ring Bell," and the other the word "OUT,"




with the expected time of return showing in a square below. By means of a rotating disc of celluloid this time may be changed, showing every hour of the day and also giving such suggestions as "five minutes," "ten minutes" and so on.

At the top of the case is an aluminum plate, with the words "leave message" and a slit through which a message may be dropped. A card case is on the front of the box, holding cards of such a size that they readily pass through the slit. The physician upon his return can readily find the messages by lifting up the front of the box. Provision is made for matches, so that the patient can see to write, and altogether the manufacturers of the little device have crowded several unique and convenient features into a space of 25 square inches. The box is handsomely finished and the complete outfit retails for $2.00.

### PNEUMATIC CUSHION.

A small device, invented for the purpose of making telephoning less disagreeable, is the "Faultless Pneumatic Cushion." As may be seen by the accompanying cut the device consists of a ring of rubber, designed to slip over the end of the receiver of the telephone and to act as a cushion for the ear. Anyone who has had the experience of holding the hard rubber receiver to his ear for several minutes will appreciate the comfort which may be derived from this little device. It is said to improve hearing and it certainly does largely away with the concussion and shock to the ear incidental to long telephoning. It can be removed and washed readily—not an inconsiderable thing in its favor. It retails for 50 cents.

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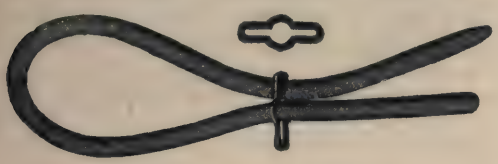
### NEW TOURNIQUET.

A new tourniquet, the advantages of which will be evident upon inspection of the cut, is illustrated herewith. Among other advantages possessed by this new device are the facts that it is easily applied to any portion of the body with great rapidity and that once in situ it will not slip until the physician desires to



remove it. Then it becomes a simple matter to take it off. It is one of the most powerful of tourniquets and owing to the means devised for holding the rubber cord, it is durable, as there is little wear on the restricting portion. Arrest of circulation is accomplished with less damage to tissue than is the case with other tourniquets and yet the arrest is prompt and efficacious.

The tourniquet is made by a well known rubber house and its retail price to the profession is $1.00.

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**Cirrhosis of Liver Diagnosed.** — Dr. James C. Wilson, of Philadelphia, at a recent meeting of the New York Academy of Medicine, read a paper on this subject. He said that it was unfortunate that the name cirrhosis had come into use; for, while it had been applied originally because it signified a yellow or tawny color, and this was more or less descriptive of certain forms of this hepatic affection, it gave no direct and accurate conception of the pathological condition. It was now asserted that atrophic and hypertrophic cirrhosis of the liver are not, as formerly supposed, merely different varieties of the same disease, but totally different diseases Again, the term atrophic cirrhosis was likewise misleading; for statistics had shown that the hob-nail liver, to which it had been originally applied, was not necessarily smaller than the normal, and might even be larger. No definition could be framed which would include, both pathologically and clinically, all forms of so-called cirrhosis of the liver. The one underlying pathological process common to all the varieties is an overgrowth of the connective tissue of the liver. Chronic interstitial hepatitis was a sufficiently comprehensive term, and should be more generally used. Certain infections, toxæmias, and mechanical irritation give rise to interstitial hepatitis. Not all forms of chronic interstitial hepatitis could be recognized. A high degree of atrophy may occur, provided the collateral circulation has been established without other symptoms directing attention to the liver. Adhesive pyelo-phlebitis closely resembles the atrophic form of interstitial hepatitis. The rapidity with which the peritoneal effusion reforms after tapping is an important diagnostic sign. The hypertrophic form of interstitial hepatitis often presents insuperable difficulties of diagnosis in the early stage. The recurrence or persistence of jaundice, its intensity, and the presence of bile in the stools, were of diagnostic importance. After the disease had become established, the uniform enlargement of the liver, the splenic tumor, the occasional attacks of jaundice, and the fever were diagnostic. Chills and sweating are not common, thus serving to differentiate it from impacted gallstones. In terminal conditions, the diagnosis is a comparatively simple matter.—(*Charlotte Medical Journal.*)

# THERAPEUTIC BREVITIES

**Rapid Dilatation of the Eustachian Tubes.**—Dr. W. Scheppegrell, writing in *Advanced Therapeutics*, says: "The mechanical method simply stretches the stricture, which soon returns to its former condition. In the more obstinate cases the electrolytic method is preferable, as it is of permanent benefit.

The bougies are made of gold, and are passed through a silver catheter insulated with a thin rubber tubing. The catheter is carefully inserted into the mouth of the eustachian tube, which has previously been cocainized, and the bougie pushed forward until it meets with an obstruction. A current of three or four milliamperes is then passed for twenty seconds to one minute, when the bougie will be found to pass forward with slight resistance, the patient at the same time hearing a "frying" sound characteristic of the electrolytic process. The patient holds the positive electrode, while the bougie is attached to the negative pole. The application should not be repeated for a week, so as to allow the reaction and congestion to subside. After sufficient dilatation has been obtained, the usual treatment by inflation and vaporization should be carried out.

"This method should be attempted, however, only by those who are familiar with the manipulation of the catheter for the eustachian tube. As the parts are cocainized the patient cannot render any assistance from his own sensations, and it is thus quite easy to injure the nasopharynx or the eustachian opening. Even the correct electrolyzation of the eustachian tube may produce ulceration and consequent retraction, so that the method should be followed only in the most careful manner."

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**Baryta Carbonica Symptoms.** — The Baryta carbonica patient has a large head, scrawny neck, unhealthy hair, hypertrophied tonsils, ungainly gait and a heaviness of the head which renders study difficult.—(*Medical Magazine.*)

## THE TONSILS FROM A PURELY CLINICAL POINT OF VIEW.*

Extract from Paper
BY FRANCKE H. BOSWORTH, M. D.

"As to the instrument to be used, I will say that for the last ten years I have ceased entirely to cut tonsils with a tonsillotome. No tonsillotome has ever been devised which will fit itself so completely over the growth as to thoroughly extirpate it in every instance. The cold wire snare adapts itself so admirably in every way to the operation that it seems to me that it leaves nothing to be desired. The loop can be arranged in such a shape and size as to perfectly fit over the mass and can be slipped between it and the facial pillars in such a manner as to secure the thorough removal of the growth much more effectually than is possible with the use of the tonsillotome. Furthermore, if the whole mass is not extirpated with the first manipulation, it is a very simple matter to repeat until the facial pillars drop into their normal position. The danger of hæmorrhage, as I have always claimed, does not present itself, especially in operating on children, but in operating on adults a very considerable hæmorrhage, which may even reach the dangerous stage, is always to be anticipated when the knife is used. With the snare this danger is practically eliminated, and to one who has met with severe hæmorrhage after tonsillotomy, this is no slight consideration.

*Transactions of 23rd Annual Meeting of the American Laryngological Association, 1901.

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**A Good Liniment.**—The following may be regarded as the type of a preparation for external use in painful conditions of the large cavities and the joints. Where it is possible to use heat and friction the action of this preparation will be enhanced:

| | | |
|---|---|---|
| ℞ | Lin. bellad., | ℥iss. |
| | Ext. opii., | |
| | Ext. bellad., | |
| | Ext. hyoscyam., *aa.* | ʒss. |
| | Chloroformi, | ʒii. |

M.
S.—For external use.
—(*Clinical Review.*)

**Summer Diarrhœa.**—"T," in *Pediatrics*, lays down the following rules for treatment:

"1.—Clear the bowels as quickly as possible, by stomach washing, colon irrigation and small, frequently repeated doses of calomel.

"2.—Starve for twenty-four hours, give ice-water with brandy if necessary.

"3.—When the acute symptoms have passed, give egg albumen, water, and subsequently beef juice.

"4.—Withhold cow's milk until the third or fourth day and then commence with .5 per cent. fat and .5 per cent. proteids, gradually increasing the strength.

In cholera infantum give hypodermic injections of morphine gr. 1-100 and atropine gr. 1-800 hourly if necessary, as a cardiac stimulant. If there is drowsiness and coma give alcohol instead. Replace the fluid lost by subcutaneous saline injections, gr. 45 ad Oj in the twenty-four hours."

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**Tetanus Treatment.**—Dr. F. A. Packard stated that the only cases of tetanus he had seen recover were those treated by injections of carbolic acid, every case treated by anti-toxin having died. Twenty-five grains of the drug may be given in twenty-four hours with no symptoms of poisoning. Whether or not it possesses a specific action against the toxins of tetanus, he is convinced that its use is the one way of curing tetanus if cure be possible. Dr. Packard uses vaccine shields and believes that they do harm only when so tight as to obstruct the circulation of blood or lymph. All the very sore arms under his observation were those on which he had used a gauze dressing, it seeming to act as a mechanical irritant. The shield is to be preferred if it be removed at the end of forty-eight hours.—(*Medical News.*)

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**For Light Burns.**—A very soothing application for burns of mild degree, and particularly for scalds from water or steam, is the following:

℞ Cocaine, gr. v.
Ung. zinci oxidi, ʒi.
M.

A thin coating may be spread upon gauze and applied to the part.

—(*Clinical Review.*)

**Beri-beri and the Heart.**—Dr. Arthur Stanley in the *Journal of Tropical Medicine* closes a paper as follows:

(1). Beri-beri has a marked degenerative action on the heart muscles, which frequently causes fatal circulatory failure. (2). In this respect beri-beri resembles other toxæmic diseases, such as diphtheria, influenza, and alcohol and arsenic poisoning, which often cause peripheral neuritis, and also other toxæmic diseases, such as typhoid fever, plague, and acute rheumatism, which do not, or rarely, give rise to peripheral neuritis. (3). Beri-beri and diphtheria are the diseases *par excellence* in which sudden fatal heart-failure occur. (4). The heart muscle degeneration is not a secondary result of neuritis of the vagus. (5). The heart muscle degeneration takes place, as a rule, before skeletal muscle degeneration, and is the result probably of direct action of the tovine, and not a secondary result of nerve change. (6). Sudden heart-failure does not indicate a sudden lesion, but rather is the result of a gradually increasing heart weakness from cardiac muscle degeneration, which may be precipitated by any sudden exertion, but more frequently is the result of the principle of "all or nothing"—the transition of from "all" to nothing being necessarily rapid. (7). The cardiac physical signs in beri-beri closely resemble those found in diphtheria, and are of paramount importance in prognosis and treatment.

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**Epidemic Dysentery in a Fœtus.**—Markwald, in the *Münchner Medicinische Wochenschrift*, reports the following:

"A patient, in the seventh month of pregnancy, came to the hospital presenting symptoms of severe dysentery. Two days later spontaneous labor resulted, and a deeply asphyxiated child was born. All efforts to save it were futile. The post-mortem revealed in the intestines the lesions of dysentery. Cultures from the blood in the right ventricle showed the presence of the bacillus dysenteriæ (Kruse). This is the only case reported in the literature in which it has been definitely demonstrated that dysentery is directly transmissible from the mother to the fœtus in utero."

**In Prolapse of the Cord.**—Dr. H. Henne, in *Centralblatt für Gynakologie,* is quoted as having followed the subjoined method. "After all other well-known means had failed the cause of such failure was found to be the attachment of the placenta, which was very low down and caused the head of the child to remain in the right aspect of the canal. The method he followed was suggested by the retention of loops of intestine away from the operative field in abdominal sections by means of gauze pads. He took a clean towel, soaked it in a one-per-cent. solution of lysol and squeezed it dry. He folded this into a pad, passed it into the vagina and then, after replacing the cord, gently forced the towel up into the uterus in such a position that the cord rested upon it and was retained by it. The procedure was easily carried out with the help of profound narcosis. The head of the child, of course, had to be pushed upward into the uterus. The intra-uterine hand of the operator was maintained within the canal until pains again appeared. It then guided the head of the child into its proper position and rendered the action of the towel more satisfactory. In this case the remainder of the delivery was normal and entirely free from a recurrence of the prolapse."

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**Dietetic Treatment of Epilepsy.**—Balint, in an article on this subject in the *Berliner Klinische Wochenschrift,* draws the following conclusions:

1. Diet containing a minimum of chlorides is applicable to every case of epilepsy and should be tried.

2. Treatment succeeds best in an institution.

3. A rigid diet of small chloride content should be instituted in every case until the character of the disease has been definitely determined.

4. Small doses of bromide may be administered in addition to (3).

5. The method of administering bromides with the foods, especially as a substitute for common salt in bread, is recommended.

6. The sedative action of bromine in this method of administration is greatly increased, and may therefore be employed in other nervous affections in which a pronounced bromide effect is desired.

**Nailing the Femur in Intracapsular Fracture of the Hip.**—Dr. Charles E. Thompson, is reported in the *St. Paul Medical Journal* as having made use of a silver nail in treating a fracture. Clinical notes are subjoined: "Patient aged 62 years; sustained fracture August, '99; bedridden three months; 2½ inches shortening; hip very painful; operation consisted of one horse-shoe incision around trochanter major, flap being elevated. Second flap consisted of periosteum, and 1-3 thickness of shaft of bone, extending 2½ inches below tip of trochanter, freed and elevated from below, leaving muscular attachments to trochanter intact. Several pieces of loose bone removed from seat of fracture. Solid silver nail 3-16 of an inch in in diameter and 2½ inches long was driven through the neck and into the head of the femur; bone flap replaced and retained by small silver nail. Wound closed by catgut suture. Entire limb and body encased in plaster of Paris spica. Patient left hospital at end of six weeks. One year after operation patient had 3-4 inches shortening, 90° free and painless motion. Walked without crutch or cane. Died of intercurrent disease six months later. Specimen obtained showing firm bony union."

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**Alopecia Areata.**—Shampoo the region every day, then bathe with carbon tetrachloride, which removes grease and micro-organisms, and rub in with slight friction:

| | | | |
|---|---|---|---|
| R | Hydrargyri bichlor.. | 0.90 | (gr. 14) |
| | Camphor ..... | 60.0 | (℥ij) |
| | Spt. terebinth..... | 60.0 | (℥ij) |
| | Spt. lavand..... | 30.0 | (℥j) |
| | Alcohol .....300.0 | | (℥x) |

The neighboring parts should be depilated and touched with a pencil made of

| | | | |
|---|---|---|---|
| R | Sulphur precip... | 0.50 | (gr. viij) |
| | Resorbin .....1.50 | | (gr. xxiij) |
| | Chrysarobin | | |
| | Paraffin, aa.....2.50 | | (gr. xl) |
| | Ol. theobrom.....3.50 | | (gr. lv) |

Or a cotton roll dipped in strong carbolic may be laid on until the parts are blanched when further action of the carbolic is stopped by applying pure alcohol.—HALLOPEAN, in *Le Bulletin Général de Thérapeutique.*

# NOTES & COMMENT

**Sterile Marriages.**—Dr. Oscar J. Price, in the *Clinical Review*, contributes an able article on the causes and takes occasion to say some very good things on the moral side of sterility. He says: "The number of sterile marriages is far greater than it is usually believed to be. In this connection, I quote from the valuable paper of Dr. George Engelmann, of Boston (formerly of St. Louis), upon this subject, read at the last meeting of the American Medical Association at St. Paul: 'Sterility among the laboring classes in St. Louis is 21 per cent.; varying in different groups—20.4 to 23.7 per cent. In Boston 23.7 per cent.; and 20 per cent. for all American born throughout the entire state, according to the Massachusetts census of 1898. My own records in private practice in St. Louis shows 23.6 per cent. of native Americans barren, and Americans of German parentage 26.3 per cent., an unusually high rate, which harmonizes, however, with the condition in Boston among Americans of Irish parentage, 27.2 per cent. An equally high sterility, in fact higher than among any other group, is attained by the college graduates, of whom comparatively few marry, and a large proportion of those who do marry are barren (33.7 per cent.), as reported in the investigation of 1885, and 20.5 per cent. in 1900, averaging 27.3 per cent. My own records of Irish and German give only 17 per cent. Among Negros, where invariably I find unfavorable functional conditions, 24 per cent. In Massachusetts 20.2 per cent. of Americans are childless, and only 13.3 per cent. of foreigners. Germans 11.2, French and Irish 11.6, English 14.4 and English Canadians 19.5 per cent.'

Again, 'Foreign records show a great variation from the lowest sterility in Norway (2.5 per cent.), and in one of the districts near Moscow (2.8 per cent.), to 27.3 per cent. in Paris, Lyons and Rouen. (In some of the departments in France only 16.8.'"

**Persistent Ectopic Gestation.**—In the *Dominion Medical Monthly* Dr. George Elliott records some strange cases observed by Dr. J. F. W. Ross. He says:

"Dr. J. F. W. Ross, for the fourth time, has met with ectopic gestation, twice in the same patient. Dr. Ross then gave the history of the case. In 1898 a woman had hæmorrhage, lasting for three weeks. On examination, a mass was found behind the uterus, and a diagnosis of rupture of pregnancy made. Operation was performed, and a blood-clot found shut off by adhesions. A good recovery was made. In June, 1901, the same patient had indefinite pains and flow of blood from the uterus. On careful examination a very small nodule was found on one side of the uterus. It was not easy to feel it, but it could be distinctly made out, and it was separate from the ovary. A delay of two weeks ensued, and patient came back at the end of that time for re-examination. The nodule had enlarged to about double the size. There were no other signs of pregnacy present. Operation followed, and Dr. Ross stated that this was the smallest unruptured ectopic gestation he had ever seen. The patient made an uninterrupted recovery.

"Dr. Ross then reported the following case, which had come under his care since the one above reported. On examination, a blood-clot could be felt breaking down in the pelvis, the mass being chiefly felt on the left side. She was taken ill with sudden severe fainting while lying in bed. She had a peculiar coloring of the skin and collapsed look. She had very little menstruation in September and October. As soon as this gestation sac was removed, the finger was passed down to the left side, and another one was found on that side, a three and one-half months' fetus, and the right one was certainly active, as well as the left. The peritoneal cavity was washed out rapidly, and salt solution had to be given and the legs bandaged. The wound was closed with through-and-through sutures. At the time of reporting the case the patient was going on to recovery."

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**Vena Cava Injured in Nephrectomy.**—Lindner, writing in the *Muenchener Medicinische Wochenschrift*, speaks of this unusual accident to a patient aet. 62, whose kidney he was in the act of removing for

the cure of a large movable tumor which affected the right organ. The mass was being delivered from the wound when there shot up from the depths a tremendous stream of dark blood, causing the operator to exclaim that the vena cava had been torn. As soon as the wound was clear enough to permit of its depths being inspected, it was seen that this was exactly what had happened. The two ends were caught and ligated, but the patient died in a few hours as the result of air having entered the heart. It was shown that a part of the vena cava had been completely grown around by the tumor, consequently in removing the same the involved section of the vessel was torn out. Eight such accidents are reported in the literature. Twice the same vessel has been ligated as an operation of choice, and without causing the death of the patient; a fact of decided interest to physiologists and surgeons.

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**Resorcin Poisoning.**—Dr. A. Caillé, in *Pediatrics,* reports a case of this kind in a five days' old infant. Resorcin, gm. 0.015 (gr. ¼) every four hours, was ordered, and after the sixth dose the child became cyanotic, pulseless, cold and clammy, and the urine voided before collapse set in had a smoky color. The child was given a hot bath (110° F.) every two hours and kept warm by hot-water packs; the bowels were flushed with a very warm saline solution every three hours, and warm sweetened tea was given by spoon frequently. As soon as the child was out of collapse it was put to the breast, and in a few days its recovery was complete.

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**Gonococcus in Blood.**—Dr. E. Unger, in the *Deutsche Medicinische Wochenschrift,* is reported as having discovered and demonstrated the gonococcus in blood. It was in a case of gonorrheal urethritis complicated by an arthritis involving the ankle, hip, and wrist joints. Aspirations of blood from the median vein when mixed with bouillon or blood-serum showed on culture colonies of diplococci which decolorized by Gram stain. The author advises three precautions in the use of this method for diagnosis: (1) Use fairly large quantities (5 c.c.) of blood, so as to obtain as many bacteria as possible; (2) dilute the blood considerably, so as to decrease its bactericidal properties; (3) select a fluid culture medium, which permits rapid, unresisted development.

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**Graduated Fees.**—"While it is a very difficult thing to adjust a medical practitioner's fees according to the equitable value of service to the patient, it is not so difficult, in theory at least, to grade fees with a fair degree of consideration of the financial ability of the patient to pay. It is not reasonable to expect the laboring man to pay two dollars for a call, and expect no more from the man who lives on the avenue and is generally held to have an income of ten thousand a year. He should, by right, pay five or ten dollars a visit, and feel perfectly satisfied in so doing. A physician's services should not be bartered the same as a yard of cloth, a pound of nails or a bushel of potatoes. An attorney never forgets or neglects to charge his wealthy client a good, round price for much the same service that, to a laboring man, he would expect to ask but little. The clergyman always looks for from twenty-five dollars upwards as a wedding fee in the case of wealthy parishioners, while one or two dolars is fair compensation from the man in a shop or clerkship.

"In surgical work, and also in obstetrical practice, the graded fee is in esteem and is becoming more firmly fixed every day. Probably the time is not far away when for every-day calls something of the same wisdom will obtain, reducing at one end of the line of patients and raising at the other extremity."—(*Clinical Review.*)

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**Some of Them Manage It.**—Dr. A. K. Steele, in a paper read before the Chicago Medical Society, states that there is an unusual amount of ignorance both on the part of the public and of the profession regarding the incomes of physicians. Professional incomes are greatly overestimated. The income of the average physician in Chicago varies from $1,500 to $3,000 per annum; office specialists—eye and ear, nose and throat—average $3,000 to $6,000; consulting physicians, $5,000 to $15,000; six leading physicians, $15,000 to $35,000; six leading surgeons, $20,000 to $60,000; six leading gynecologists, $10,000 to $20,000; six leading office specialists, $10,000 to $15,000; average surgeons, $3,000 to $10,000. The practition-

ers in Chicago whose income from practice exceeds $30,000 per annum can be counted on the fingers of one hand, and probably not more than a score exceed $20,000 per annum. The $2 to $3 visit, the $5 to $25 consultation, the $18 to $30 case of obstetrics, and the larger fees provided for operative work do not insure large incomes for many in the profession. The expenses of a physician keep pace with his increasing business, so that the opportunity for accumulating wealth is not easy.—(*Courier of Medicine.*)

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**Methyline Blue in Otitis.**—*Merck's Archives* quotes Prof. H. Gaudier as follows: "After having cleansed the canal by means of a warm soap and water injection, the patient turns his head to one side, and 15 to 20 drops of the solution mentioned above are instilled into the ear. This procedure lasts five minutes and during this time the patient performs the maneuver of Valsalva; that is, he makes a forced expiratory movement, while keeping nose and mouth closed. Air is thus forced into the ear and the methylene blue passes from the canal into the tympanic cavity. Nine old cases, with perforation of the tympanum, treated in this manner, showed marked improvement. The deodorizing properties of methylene blue render it superior to other antiseptics, and the purulent discharge diminished under the influence of the remedy more rapidly than under any other treatment.

"In ordering methylene blue, emphasis should be laid upon getting a pure medicinal article, as there is a dye on the market of the same name."

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**Very Low Rates to the Northwest.**—March 1 to April 30, 1902, the Chicago, Milwaukee & St. Paul will sell tickets to Montana, Idaho and North Pacific coast points at the following greatly reduced rates: From Chicago to Butte, Helena and Anaconda, $30.00; Spokane, $30.50; Portland, Tacoma, Seattle, Victoria and Vancouver, $33.00. Choice of routes via Omaha or St. Paul to points in Montana, Oregon and Washington.

For further information apply to any coupon ticket agent in the United States or Canada, or address Robt. C. Jones, Michigan Passenger Agent, Detroit, Mich.

**Vaccination Points.**—Dr. A. J. Harrington, in the *Canadian Journal of Medicine and Surgery,* among many other interesting things, lays down the following: "The spot that is to be vaccinated should be carefully cleansed with soap and water and then dried. No antiseptics should be applied to the skin at this time. A small area should be scarified with a needle which has been previously sterilized by passing through the flame of an alcohol lamp or a Bunsen burner, and the lymph (always glycerinized lymph in the tube) is applied to the scarified area and thoroughly rubbed in. Do not draw blood if you can possibly avoid it, as a gentle oozing of serum gives much better results. If you draw blood, while it is drying the fibrin of the clot contracting forces the lymph through the serum to the surface as in ordinary coagulation of the blood and the effect of the vaccination is lost, and this is a great cause, to my mind, of the majority of cases where vaccination does not take in persons who have not previously been vaccinated. Now, give plenty of time for the lymph to dry thoroughly, then apply a clean piece of cotton or absorbent cotton over the vaccinated area, and retain it in place with adhesive plaster. This method of vaccination requires much more time than the old way, but the difference in results will well repay the additional care, and sore and swollen arms will be a rarity."

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**Puerperal Convulsions.**—Of leading importance, and, to a degree, in the relative order of value or application, the following procedures occur:

1. Immediate and rapid delivery, regarding the mother first, the child secondarily.
2. Narcosis during the delivery and the employment of means leading thereto.
3. Signal attention to aseptic and antiseptic rules.
4. Careful selective regard in using chloral, ether, chloroform, morphia, veratrum viride, etc.
5. Prompt opening of all excretory avenues.
6. Dilution of toxin-loaded blood by saline infusions.
7. Prompt stimulation in the event of evidences of cardiac failure.—(*Clinical Review.*)

**Good for the Court.**—The Supreme Court of Indiana has recently handed down an opinion on the right of a physician to refuse to treat a case. The question was settled in connection with a lawsuit resulting from the fact that the physician was called to attend a person dangerously ill, but refused to go, and the patient died; and it was alleged that no other physician could have been called in time to be of service.

The court held in favor of the physician, that he is not liable for refusing to respond to a call, even though he may be the only one available.

In construing the Indiana statute regulating the practice of medicine, the court said: "That in obtaining the State license to practice medicine, the State does not require, and the license does not engage, that he will practice at all, or on other terms than those he may choose to accept."

We see no distinction or difference in such a case between the duty of the physician and the lawyer, and no one would hold the lawyer could be compelled to take a case for a client unless he was willing to do so.

We can understand how all might feel that a physician who refused to take a case in an emergency, when no one else could be got in time, and death resulted in consequence, should be generally censured, and the case would be a calamity, but that certainly should not establish a legal liability.—(*The Medico-Legal Journal.*)

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**Peroxide in Dysentery.**—Rocaz, in the *Journal de Médicine de Bordeaux,* comments favorably on the use of this antiseptic in cases of dysentery in children. Lavage with hydrogen peroxide was practised 2 or 3 times daily; the effect was speedy and marked. Within two or three days the character of the stools changed materially; blood and mucous disappeared, the stools became less and less frequent, and the sphincter regained its tonicity. He states that in order to secure a cure it is necessary to continue medication some days after subsidence of symptoms.

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**One in 10,000.**—Insurance tables show that in Germany only one person in 10,000 reaches the age of 100 years.—(*Exchange.*)

# BOOK REVIEWS

**A System of Physiologic Therapeutics. A Practical Exposition of the Methods, Other Than Drug-giving, Useful in the Treatment of the Sick. Edited by Solomon Solis Cohen, A. M., M. D., Professor of Medicine and Therapeutics in the Philadelphia Polyclinic; Lecturer on Clinical Medicine at Jefferson Medical College; Physician to the Philadelphia and Rush Hospitals, etc. Volumes I and II. Electrotherapy. By George W. Jacoby, M. D., Consulting Neurologist to the German Hospital, New York City; to the Infirmary for Women and Children; and to the Craig Colony for Epileptics, etc.**

As is stated in the general introductory remarks by Dr. Cohen in volume I, these two volumes by Dr. Jacoby on Electrotherapy are the first of a series of eleven volumes on physiologic therapeutics.

In reviewing these two books on electricity and electrotherapeutics one is struck by the very able manner in which Dr. Jacoby has handled the subject.

Volume I is devoted to electrophysics, to the description of electrical apparatus and the various methods of the use of the same with a special section on Skiagraphy and the Roentgen ray.

Volume II treats of the diagnostic and therapeutical uses of electricity with the various modes of application.

Both books are concise and full of valuable information both for the student and practitioner.

The entire series would undoubtedly be a desirable addition to any library.

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**A Treatise on the Acute, Infectious Exanthemata.—Including Variola, Rubeola, Scarlatina, Rubella, Varicella, and Vaccina, with especial reference to Diagnosis and Treatment. By William Thomas Cortley, M. D., L. R. C. P. Lond.; Professor of Dermatology and Syphilology in Western Reserve University. Illustrated by 12 colored plates, 28 halftone plates from life, and 2 engravings. Philadelphia: F. A. Davis Company, Publishers, 1914-16 Cherry Street.**

The acute exanthemata are exclusively and exhaustively treated by Dr. Corlett, who prefatorily notes the difficulties encountered by the young practitioner in making an accurate diagnosis of any of the exanthemata when the

forms are so many and varied. Then he goes on, in the body of the book, to explain much that is of value to the student and to the old practitioner alike, carefully written and well illustrated as his words are. A valuable chapter on scarlatina is contributed, every form of this disease being treated with minute care, and an able setting forth of fumigation methods finds a place here also. Variola and Vaccinia engage the author's attention for one-third of the text, but possibly this is not too much space to give them. The publishers have done their full share to make the book attractive.

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Progressive Medicine, Vol. IV., 1901. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 400 pages, 13 illustrations. Lea Brothers & Co., Philadelphia and New York.

The present volume of this well-known quarterly is of special interests to physicians in that it contains the following articles: Diseases of the Digestive Tract and Allied Organs, the Liver, Pancreas, and Peritoneum, by Max Einhorn, of New York; Genito-Urinary Diseases, by William T. Belfield, of Chicago; Anæsthetics, Fractures, Dislocations, Amputations, Surgery of the Extremities, and Orthopedics, by Joseph C. Bloodgood, of Baltimore; Diseases of the Kidneys, by John Rose Bradford, of London; Physiology, by Albert F. Brubaker, of Philadelphia; Hygiene, by Henry B. Baker, of Lansing, Mich.; Practical Therapeutic Referendum, by E. Q. Thornton, of Philadelphia.

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A Text-Book on Diseases of the Ear, Nose and Throat. By Charles H. Burnett, M. D.; E. E. Fletcher Ingalls, M. D., and James E. Newcomb, M. D. With Numerous Illustrations. Philadelphia and London: J. B. Lippincott Co. 1901.

Collaboration has been very successful in this volume. Several specialists have combined to put their knowledge into readable shape, and the result is gratifying. Three divisions are made, each one written by a practical man. Dr. Charles H. Burnett, of Philadelphia, writes on diseases of the ear. Diseases of the nose and naso-pharynx are written of by Dr. E. Fletcher Ingalls, of Chicago, assisted by Dr. Otto F. Freer, of the same city. Diseases of the pharynx and the larynx are described by Dr. James E. Newcomb, of New York City. The latest discoveries in the several departments are incorporated in the work by the writers, who have written thoroughly and with authority. The arrangement of matter commends itself both to the general practitioner and to the specialist.

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Phototherapy. By Prof. Niels R. Finsen of Copenhagen. Translated from the German Edition and with an Appendix on the Light Treatment of Lupus by James H. Sequeira, M. D., Lond., M. R. C. P. Edward Arnold, London.

Prof. Finsen's achievements along his chosen line are well known to the profession and his translator has dealt kindly with him. The book consists of three monographs by Finsen, "The Chemical Rays of Light and Smallpox," "Light as a Stimulant" and "The Treatment of Lupus Vulgaris by Concentrated Chemical Rays."

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The Principles of Hygiene. A Practical Manual for Students, Physicians and Health Officers. By D. H. Bergey A. M., M. D., First Assistant, Laboratory of Hygiene, University of Pennsylvania. Illustrated. Philadelphia and London: W. B. Saunders & Company, 1901.

Books on Hygiene are by no means rare and Dr. Berger may have had some misgivings as to the reception his book would meet; but it is an interesting work, one that will take a high rank among the other volumes on the same subject. The author has sensibly discarded the terms "contagious" and "infectious," and makes use of "transmissible" instead. Typographically, the volume is admirable.

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The Standard Medical Manual. A Handbook of Practical Medicine. By Alfred S. Burdick, M. D., Editor of Medical Standard; Junior Professor of Practice in the Illinois Medical College. G. P. Englehard & Co., Chicago.

A handy book on practical medicine, with the subjects placed in alphabetical order. It is likely to be much used by those who read it.

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A Practical Treatise on Materia Medica and Therapeutics, With Especial Reference to the Clinical Application of Drugs. By John V. Shoemaker, M. D., LL. D., Professor of Materia Medica, Materia Medica, Pharmacology, Therapeutics, and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia, etc. Fifth Edition, Thoroughly Revised. Pages 8-1143. Size 9¼x6¼ inches. Extra Cloth, $5.00 net; Sheep, $5.75 net. Delivered. Philadelphia, Pa.: F. A. Davis Co., Publishers, 1914-16 Cherry St.

A Brief Manual of Prescription-Writing in Latin or English for Use of Physicians, Pharmacists, and Medical and Pharmacal Students. By M. L. Neff, A. M., M. D., Cedar Rapids, Ia. Pages 5-152. Size 8x5¾ inches. Extra Cloth, 75 cents, net, Delivered. Philadelphia, Pa.: F. A. Davis Co., Publishers, 1914-16 Cherry St.

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Manual of Physical Diagnosis. For the use of Students and Physicians. By James Tyson, M. D., Professor of Medicine in the University of Pennsylvania and Physician to the University Hospital; Physician to the Philadelphia Hospital; Fellow of the College of Physicians of Philadelphia; Member of the Association of American Physicians, etc. Fourth Edition, Revised and Enlarged. With Colored and other Illustrations. Published by P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. 1901. 12mo. Cloth, $1.50 net.

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Lea's Series of Pocket Text-Book: A Pocket Text-Book of Venereal Diseases. For Students and Practitioners. By James R. Hayden, M. D., Chief of Clinic and Instructor in Venereal and Genito-Urinary Diseases in the College of Physicians and Surgeons, New York, etc. New (third) Edition, thoroughly revised. In one 12mo. Volume of 304 Pages, with 66 Engravings. Cloth, $1.75 net. Flexible Leather, $2.25 net. Lea Brothers & Co., Publishers, Philadelphia and New York.

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The Medical News Pocket Formulary, New (fourth) Edition. Containing 1,700 Prescriptions Representing the Latest and Most Approved Methods of Administering Remedial Agents. By E. Quin Thornton, M. D., Demonstrator of Therapeutics, Pharmacy and Materia Medica in the Jefferson Medical College, Philadelphia. New (fourth) Edition, Carefully Revised to date of issue. In one wallet-shaped volume, strongly bound in Leather, with Pocket and Pencil. Price, $1.50 net. Lea Brothers & Co., Philadelphia and New York. 1902.

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Progressive Medicine, Vol. IV., 1901. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, bound in cloth, 400 pages, 13 Illustrations. Per annum, in four cloth-bound volumes, $10.00. Lea Brothers & Co., Philadelphia and New York.

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The Practical Medical Series of Year-Books Comprising Ten Volumes on the Year's Progress in Medicine and Surgery. Issued Monthly Under the General Editorial Charge of Gustavas P. Head, M. D., Professor of Laryngology and Rhinology, Chicago Post-Graduate Medical School. Volume I. General Medicine. Edited by Frank Billings, M. S., M. D., Head of Medical Department and Dean of the Faculty of Rush Medical College, Chicago, with the Collaboration of S. C. Stanton, M. D. October, 1901. Price of this Volume $1.50; Price of the Series, $7.50. Chicago: The Year-Book Publishers, 40 Dearborn St.

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Operative Surgery. By Joseph D. Bryant, M. D., Professor of Principles and Practice of Surgery, Operative and Clinical Surgery University and Bellevue Hospital Medical College, etc. Vol. II. Operations on Mouth, Nose and Œsophagus, the Viscera Connected with the Peritonæum, the Thorax and Neck and Penis, and Miscellaneous Operations. This Volume contains 827 Illustrations, 40 of which are Colored. New York. D. Appleton & Company. 1901.

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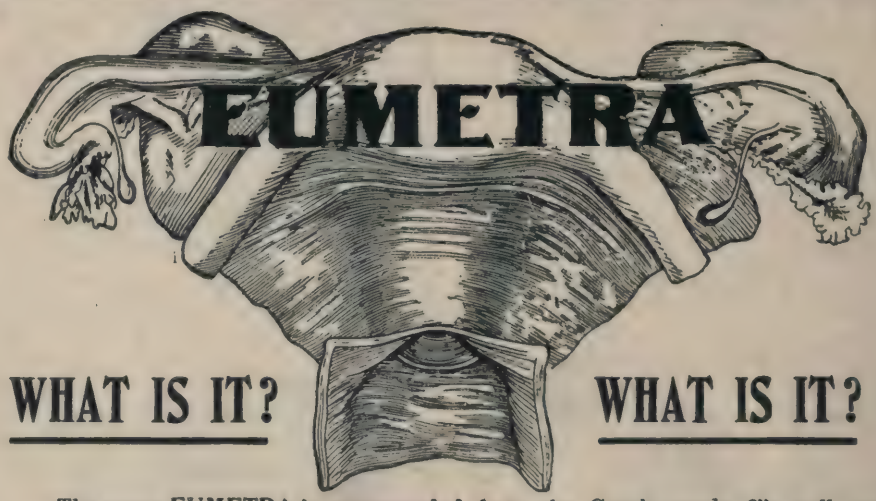


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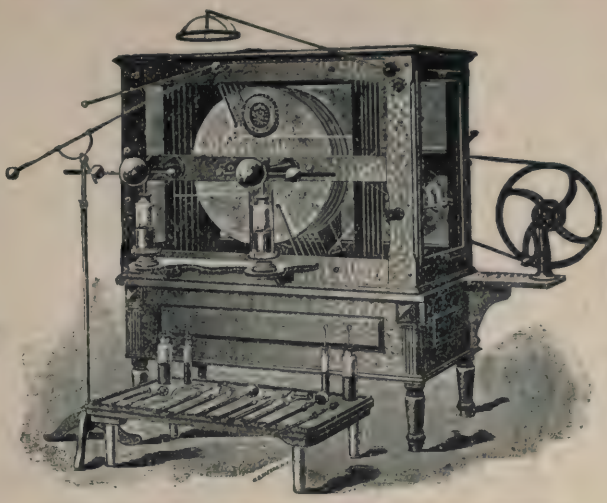

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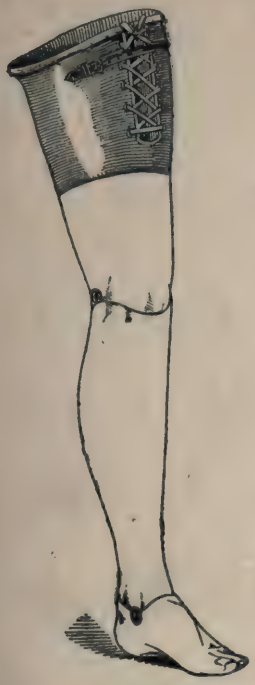

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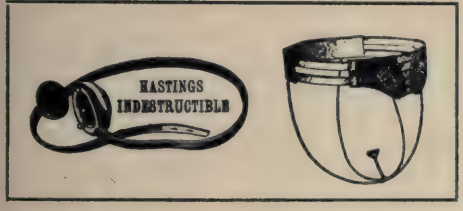


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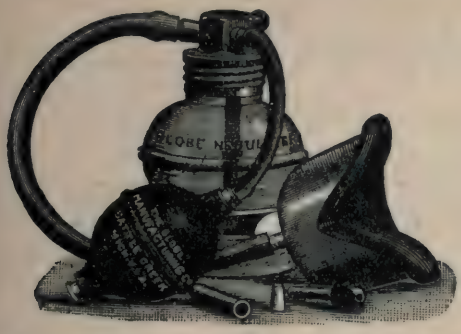

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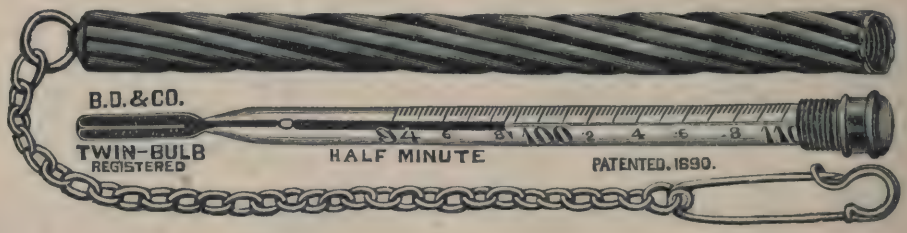


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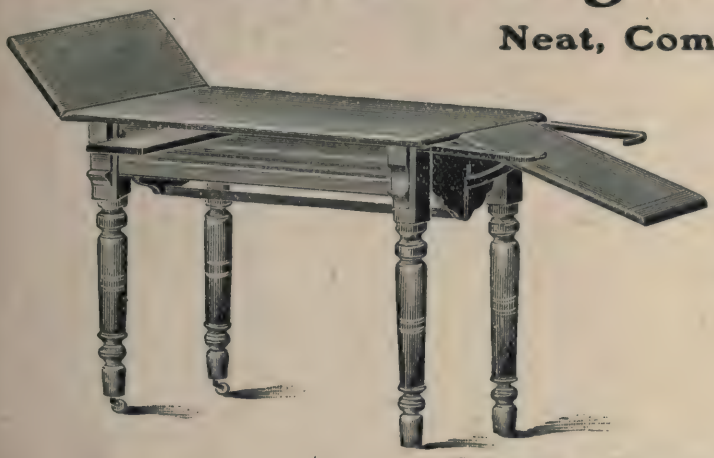

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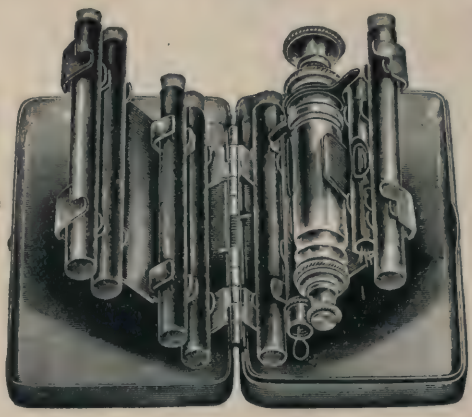

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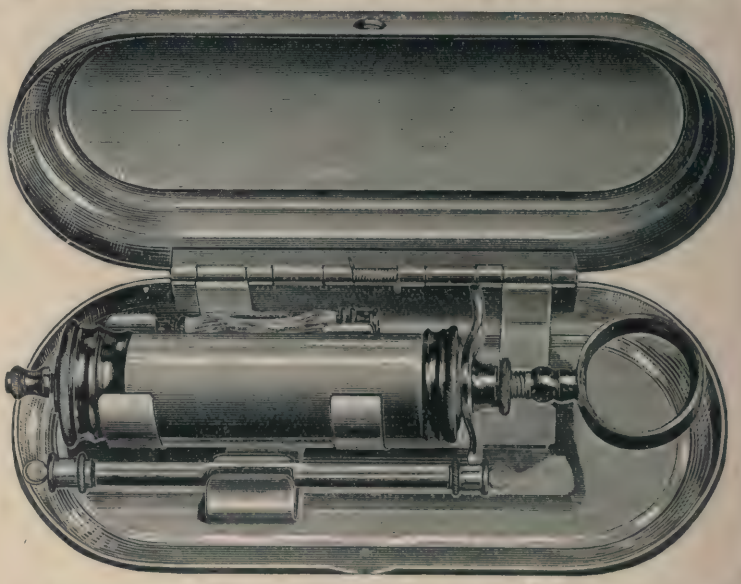

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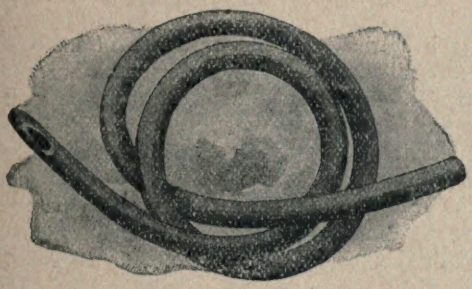

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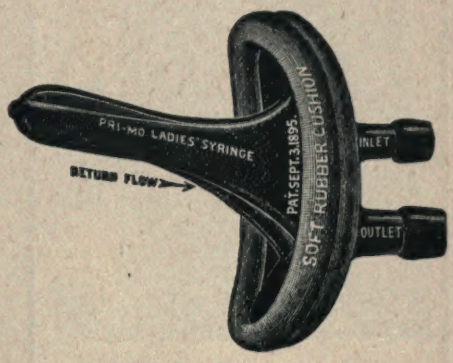


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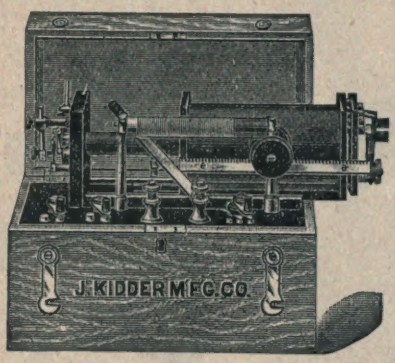


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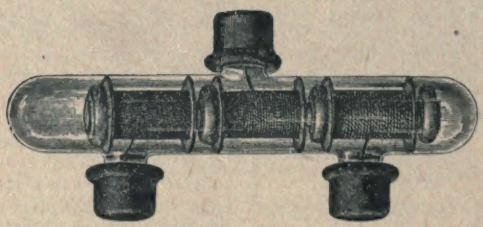

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